Sleep Health Questionnaire

Patient: _____ Date: _____

Preferred Language: _____

Interpreter Required: Type _____ Name: _____ ID# _____

Please describe your sleep problem(s) and how long this has been a problem:

_____

_____

_____

_____

Symptoms that apply to you:

□Loud Snoring □Choking/Gasping during sleep □Excessive Daytime Sleepiness □Morning Headaches

□ Stop breathing during sleep (witnessed apnea) □Nasal obstruction/congestion □Wake w/ Dry Mouth

□ Difficulty Initiating or Maintaining Sleep □ Wake feeling un-refreshed □ Suffered an accident / injury due to falling asleep

Medical History:

□Cardiovascular Disease □Stroke □Hypertension □CHF □COPD □Neuromuscular Disorders □Diabetes
□Anxiety □Depression □Impaired Cognition □Asthma □Chronic Bronchitis □Sleep Apnea □Narcolepsy
□Restless Legs □_____

Operations:

YR	Operation(s)
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalization(s) in past 12 months:

YR	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Medication(s):

_____

_____

_____

_____

Allergies: (medication/food/etc…)

_____

_____

_____

_____

Family History: Please list any major health problem(s), if deceased list the age of occurrence and cause of death:

Father: _____
Mother: _____
Sister: _____
Brother: _____

Personal History:

1. Do you Smoke: □No □Yes, how long ____ yrs, pack(s) per wk ____ Social Smoker _____
   □Former Smoker, how long ____ yrs, pack(s) per wk ____
2. Alcohol consumption: □ Never □ Rarely □ Weekend's only □ ≤ 2 oz liquor/beer/wine per day □ > 2 oz per day
3. Caffeine consumption: Occasional: ____ Daily: _____cups coffee, ____ cups tea, ____ cups soda, ____ cups energy beverage

4. Have you wished you were dead or wished you could go to sleep and never wake up during the last month? □Yes □No

5. Have you had any suicidal thoughts with a plan in the last month? □Yes □No

6. Have you had any falls within the past 6 months? □Yes □No

Sleep History: *Epworth Sleepiness Scale*: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to circle the most appropriate number for each situation:

0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Situation	Chance of dozing			
While sitting and reading	0	1	2	3
While watching TV	0	1	2	3
While sitting inactive in a public place (ex. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
While lying down to rest in the afternoon when circumstances permit	0	1	2	3
While sitting and talking with someone	0	1	2	3
While sitting quietly after lunch without alcohol	0	1	2	3
While in a car stopped for a few minutes in traffic	0	1	2	3
Circle what best describes your overall sleepiness	None	Mild	Moderate	Severe

1. How many times a night do you typically awaken? _____ Epworth Total Score _____ out of 24

2. How many hours per night do you sleep on average? _____ Mon-Thurs sleep time ____ Wake time ____

3. Do you take naps? □ Yes, how long in minutes _____ □ No Fri-Sun sleep time _____ Wake time _____

4. Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following activities?

   When you laugh □Yes □No
   When you are angry □Yes □No
   When hearing or telling a joke □Yes □No
   When tense or under stress □Yes □No
   During exercise □Yes □No
   Other: If yes specify: _____

5. Are your dreams so real that you cannot tell if you are awake or asleep? □Yes □No

6. On occasion do you awaken soon after going to sleep or in the morning feeling paralyzed, unable to move or talk, which lasts only for a few seconds or minutes? □Yes □No

7. Have you ever suffered a head injury, meningitis, encephalitis, stroke or seizures? □Yes □No

8. Do you sleep better away from home? □Yes □No

9. Do you relate your sleep problems to a specific change or stress in your life? □Yes □No

10. If awakened do you feel it necessary to eat or drink in order to resume sleep? □Yes □No

11. Do you use prescription or over the counter medicines to help you sleep? □Yes □No

12. Do you typically have sleepiness associated with periods, PMS, or menopause? □Yes □No □NA

13. Do you experience repetitive arm or leg movements while asleep? □Yes □No

14. Do you have leg and/or arm discomfort when going to bed or when sitting still, which goes away by moving or walking? (Answer No, if your discomfort is muscle cramping) □Yes □No

15. Do you talk in your sleep? □Yes □No

16. Do you grind or clench your teeth while you sleep? □Yes □No

17. Do you sleep walk? □Yes □No

18. Do you have episodes of extreme terror / screaming during sleep, yet have little if any recall of the event? □Yes □No

19. While asleep, have you ever acted out a dream or injured yourself or bed partner? □Yes □No

20. Do you have episodes of bed-wetting during sleep? (More than once a month) □Yes □No

21. Do you cough at night? □Yes □No

22. Do you work at night or change shifts? □Yes, describe _____ □No

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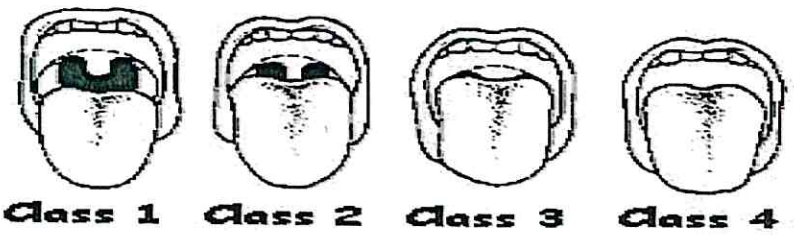
----------FOR OFFICE USE ONLY----------

Physical Exam: (To be complete by Nurse or Technologist)

Ht: _____ inches Wt: _____ lbs BMI: _____ HR: _____ BP: ____/____ BPM: _____

Nose: □Normal □Septal Deviation □Obstruction □Other _____

Neck Circumference: _____inches **Mallampati Classification**



□**Class I:** soft palate, fauces, uvula, pillars
□**Class II:** soft palate, fauces, portion of uvula
□**Class III:** soft palate, base of uvuala
□**Class IV:** hard palate only

Oropharynx: □Normal □Enlarged tongue □Long uvula □Short AP diameter □Retrognathia

Technologist: _____ Date: _____

Please return this signed form along with your Sleep Study Questionnaire on the night of your study. If you have any questions about any of the information provided in your packet, please call the lab @ 205-814-2333.

I have read and understand all of the information provided in the Sleep Patient Packet.

Signature: _____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the Week	Type of Day W/S/O/V	Noon	1 PM	2	3	4	5	6 PM	7	8	9	10	11 PM	Midnight	1 AM	2	3	4	5 AM	6	7	8	9	10	11
sample	Mon.	Work		E					A				I										C M			

week 1

week 2