Jewish Hospital & St. Mary's HealthCare

❑ JHMCE
❑ JHS
❑ SMEH

# SLEEP QUESTIONNAIRE

## 1. DEMOGRAPHIC DATA

Name: _____ Home Telephone _____

Address: _____ Work Telephone: _____

_____ Marital Status: _____

Date of Birth: _____Age:_____ Sex: ____ Height: _____Weight: _____

## 2. PHYSICIAN INFORMATION

Name of Primary Care Physician:

Dr.: _____

Address: _____

_____

Telephone #: _____

Specialty:_____

Name of Referring Physician:

Dr.: _____

Address:_____

_____

Telephone #: _____

Specialty: _____

Pharmacy & Phone #: _____

## 3. SLEEP HISTORY

Briefly describe the problem you are experiencing with your sleep (i.e. the reason you need to see the sleep physician), and when this problem first began.

_____

_____

_____

_____

_____

Operative Report

F1700

| | | |
|---|---|---|
| Have you had problems with excessive daytime sleepiness? | ❑ YES | ❑ NO |
| Have you had problems with excessive fatigue during the day? | ❑ YES | ❑ NO |
| Do you frequently fall asleep while watching television? | ❑ YES | ❑ NO |
| Do you tend to fall asleep during the day when you are quiet and inactive? | ❑ YES | ❑ NO |
| Do you feel distracted and unable to concentrate during the day? | ❑ YES | ❑ NO |
| Have you had any accidents at work due to sleepiness? | ❑ YES | ❑ NO |
| Do you have difficulty staying awake to drive? | ❑ YES | ❑ NO |
| Have you had any near traffic accidents due to sleepiness? | ❑ YES | ❑ NO |
| Have you had an auto accident in the last five years? | ❑ YES | ❑ NO |
| Has anyone told you that you snore loudly? | ❑ YES | ❑ NO |
| Do you snore in all sleeping positions? | ❑ YES | ❑ NO |
| Have you awakened with a dry, "cotton mouth"? | ❑ YES | ❑ NO |
| Has your family told you that you quit breathing at night? | ❑ YES | ❑ NO |
| Have you awakened gasping for breath? | ❑ YES | ❑ NO |
| Have you ever awakened at night with coughing, choking or respiratory discomfort? | ❑ YES | ❑ NO |
| Do you frequently awaken with a sore throat? | ❑ YES | ❑ NO |
| Do you have morning headaches? | ❑ YES | ❑ NO |
| Do you frequently sweat during the night? | ❑ YES | ❑ NO |
| Has your weight changed in the last five years?<br>If yes, how much? Gained _____ lbs or Lost_____ lbs | ❑ YES | ❑ NO |
| Have you ever awakened at night with chest tightness or discomfort? | ❑ YES | ❑ NO |
| Have you ever awakened at night with a sour taste in your mouth or a burning sensation in your chest? | ❑ YES | ❑ NO |
| Do you have sudden episodes of sleep during the day? | ❑ YES | ❑ NO |
| Have you ever experienced periods in which you feel paralyzed while going to sleep, or waking up? | ❑ YES | ❑ NO |
| Have you ever had visual hallucinations or dream-like mental images while falling asleep? | ❑ YES | ❑ NO |

| | | |
|---|---|---|
| Have you ever had sudden physical weakness while experiencing strong emotions? (For example, does your mouth drop open or do your legs go limp) when you are laughing or angry?) | ❑ YES | ❑ NO |
| Did you have childhood sleep problems of any kind? | ❑ YES | ❑ NO |
| Were you excessively sleepy as a teenager or young adult? | ❑ YES | ❑ NO |
| Do you take scheduled naps during the day? | ❑ YES | ❑ NO |
| Are you sleepy even on vacation? | ❑ YES | ❑ NO |
| Do you kick your legs at night? | ❑ YES | ❑ NO |
| Do you have "tingly" sensations in your legs and the feeling that you just have to move them? | ❑ YES | ❑ NO |
| Do you have difficulty initiating sleep at night? | ❑ YES | ❑ NO |
| Do you have frequent awakenings? | ❑ YES | ❑ NO |
| Do you usually have restless sleep? | ❑ YES | ❑ NO |
| Do you sleep better away from your own bed? (For example, while on vacation or visiting family.) | ❑ YES | ❑ NO |
| Are you sleepy even when you increase your sleep time? | ❑ YES | ❑ NO |
| Do you have pain that bothers you at night? | ❑ YES | ❑ NO |
| Do you grind your teeth in your sleep? | ❑ YES | ❑ NO |
| Have you ever had a severe head trauma? | ❑ YES | ❑ NO |
| Do you sleep walk? | ❑ YES | ❑ NO |
| Do you talk in your sleep? | ❑ YES | ❑ NO |
| Do you have frequent nightmares? | ❑ YES | ❑ NO |
| Do you ever wake up screaming at night? | ❑ YES | ❑ NO |
| Are you awake at night because of your bed partner? (noise or movement) | ❑ YES | ❑ NO |
| Are you awake at night because some other person needs assistance? | ❑ YES | ❑ NO |

## 4. SLEEP SCHEDULE

| | Weekday | Weekend |
|---|---|---|
| **Time you go to bed** | | |
| **Time you get up** | | |
| **Average amount of sleep per night** | | |

Do you have rotating or night shift work? ❑ YES ❑ NO

How long does it take you to go to sleep? _____

How do you feel when you wake up?_____

Do you function best in the morning _____ afternoon _____ or evening? _____

Do you function worst in the morning _____ afternoon _____ or evening? _____

Do you find that your present sleep schedule is inconvenient, inappropriate, or unsatisfactory? ❑ YES ❑ NO

If yes, please explain. (Example – "I can't fall asleep until late at night and then I can't get up ill time for work in the morning." or, "I fall asleep so early in the evening that I wake up early in the morning, well before it's time to go to work.")

_____

_____

_____

_____

_____

_____

## 5. PAST MEDICAL HISTORY

Have you had any surgeries? ❑ YES ❑ NO

If yes, what year?

Tonsillectomy _____ Hernia _____

Cardiac Bypass _____ Hysterectomy _____
Appendectomy _____ Nasal Surgery _____
Other _____
Do you have any medical problems? ❑ YES ❑ NO
If yes, what year?
Diabetes_____ Heart Disease _____
Ulcers _____ Thyroid Disease _____
Arthritis_____ Seizure Disorder_____
Lung Disease_____ High Blood Pressure _____
Other _____
_____
Allergies _____

6. **CURRENT MEDICATIONS**

| Medication | Dosage | Reason For Taking | How Long? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(Please include any over-the-counter medications.)

**7. SOCIAL HISTORY**

Do You work? ❑ YES ❑ NO
If yes, how much and what shift? _____

Have you ever smoked? ❑ YES ❑ NO

If yes, how long?_____ How many packs per day? _____When did you quit?_____

Do you drink alcoholic beverages? ❑ YES ❑ NO

If yes, how often? _____

Do you drink coffee, tea, or soft drinks? ❑ YES ❑ NO

If yes, regular _____ or decaffeinated_____How much daily? _____

Have you ever used marijuana, cocaine or other drugs? ❑ YES ❑ NO

If yes, which drug and how often? _____

How many meals do you eat daily? _____

Do you, exercise regularly? ❑ YES ❑ NO

If yes, what time of day?_____

## 8. FAMILY HISTORY (Mother, Father, Siblings)

| Relative | Living? | Age | If deceased at what age? | Cause of Death | Medical Problems |
|---|---|---|---|---|---|
| **Father** | | | | | |
| **Mother** | | | | | |
| **Brother/Sister** | | | | | |
| **Brother/Sister** | | | | | |
| **Brother/Sister** | | | | | |
| **Brother/Sister** | | | | | |

Do any of the above have a history of any of the following:

Diabetes ❑ YES ❑ NO If yes, who _____

Heart Disease ❑ YES ❑ NO If yes, who _____

High Blood Pressure ❑ YES ❑ NO If yes, who _____

Stroke ❑ YES ❑ NO If yes, who _____

Obesity ❑ YES ❑ NO If yes, who _____

Narcolepsy ❑ YES ❑ NO If yes, who _____

Snoring ❑ YES ❑ NO If yes, who _____

Sleep Apnea ❑ YES ❑ NO If yes, who _____

Daytime Sleepiness ❑ YES ❑ NO If yes, who _____

Other ❑ YES ❑ NO If yes, who _____

9. **SYSTEMS REVIEW**

| | | |
|---|---|---|
| Have you seen, an Ear, Nose, and Throat specialist? | ❑ YES | ❑ NO |
| Have you had sinus x-rays? | ❑ YES | ❑ NO |
| Do you have frequent nosebleeds? | ❑ YES | ❑ NO |
| Do you have nasal allergies? | ❑ YES | ❑ NO |
| Does your nose become stopped up during the year? | ❑ YES | ❑ NO |
| Do you have difficulty breathing through your nose at any time? | ❑ YES | ❑ NO |
| Do you have problems with persistent cough? | ❑ YES | ❑ NO |
| Do you have problems with shortness of breath? | ❑ YES | ❑ NO |
| Do you have problems with coughing at night? | ❑ YES | ❑ NO |
| Do you have problems with wheezing? | ❑ YES | ❑ NO |
| Do you have persistent hoarseness or difficulty swallowing? | ❑ YES | ❑ NO |
| Do you have severe heart fluttering, tightness in your chest or chest pain? | ❑ YES | ❑ NO |
| Do you have stomach burning or other signs of ulcers? | ❑ YES | ❑ NO |
| Do you take antacids? | ❑ YES | ❑ NO |
| Have you had problems with frequent urination or other urinary problems? | ❑ YES | ❑ NO |
| Have you had swelling of your hands or feet? | ❑ YES | ❑ NO |
| Do you have severe difficulties with joint pain, particularly at night? | ❑ YES | ❑ NO |
| Have you had seizures or other neurologic problems? | ❑ YES | ❑ NO |
| Have you had any problems with depression or anxiety? | ❑ YES | ❑ NO |
| Have you ever been hospitalized or treated for depression or anxiety? | ❑ YES | ❑ NO |
| In the past six months, have you had constantly low energy levels, constipation, or intolerance to cold? | ❑ YES | ❑ NO |