QUINCY MEDICAL GROUP
Sleep Center

Clinical Sleep Disorders Questionnaire

Name:________________________________ Age: ________ DOB: _________ Sex: _________

Height____ft.____inches Weight______lbs.

Address:____
(city) (state) (zip)

Home Phone(_____)______________________ Business/Cell (_____)______________________

Referring Physician_______________________ Phone Number (_____)______________________

Family Physician__________________________ Phone Number (_____)______________________

Please consult your bed partner, family member, or anyone who has observed your sleep when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. This information is confidential so please answer as completely as possible.

What is your main concern regarding your sleep? (Why did your doctor order a sleep study?)

____

____

____

What is the most you have ever weighed?____

What did you weigh 5 years ago?___________

What did you weigh 1 year ago?____________

When did your sleep problem begin? (month and year)___________________________________

Have you ever had a sleep study before? ❑YES ❑NO

If yes, where was the study performed?____

When was the study performed?____

What were the results?____

Do you wear CPAP/BiPAP or have you in the past?__________________________________

If yes, what pressure is your PAP therapy device set for? ______________________________

Drowsiness is greatest in the: ❑Morning ❑Afternoon ❑Evening

How would you rate your quality of sleep? ❑Very Poor ❑Poor ❑Fair ❑Good ❑Excellent

Are you currently on supplemental oxygen? ❑YES ❑NO ❑Only at night _____ liters per minute

Are you mobile without assistance? ❑YES ❑NO please explain: _____________________

Have you been diagnosed with high blood pressure? ❑YES ❑NO *Controlled with medication? ❑Yes ❑No*

Have you been diagnosed with heart disease? ❑YES ❑NO If yes, please describe _______________

Have you ever had a stroke? ❑YES ❑NO If yes, how long ago? ___________________________

Have you ever had a seizure? ❑YES ❑NO If yes, how long ago? ___________________________

Patient Name______________________________________ **Date** _______________________

My ideal amount of sleep is __________ hours every night.

During the **week** I usually:
Go to bed at ____________p.m./a.m. *(time)*
Get up at_______________p.m./a.m. *(time)*
I sleep a total of _________________hours

During the **weekend** I usually:
Go to bed at ____________p.m./a.m. *(time)*
Get up at_______________p.m./a.m. *(time)*
I sleep a total of _________________hours

My job requires shift work: ❑ YES ❑ NO *If yes, my hours are:* ________________________

It usually takes me __________hours_________minutes to fall asleep.

I usually wake up ________ times during the night.

Please explain what wakes you up:____

____

I have difficulty going back to sleep once I wake up: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I snore: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never *Age when I started to snore:*________

I snore in all positions: ❑ YES ❑ NO *Position in which snoring is worse:* __________________

My snoring has been described as: ❑ Light ❑ Moderate ❑ Loud ❑ Very Loud

I have problems with my nose or nasal breathing: ❑ YES ❑ NO
*If yes, please describe:*____

I wake up in the night gasping for air, wheezing,
short of breath or feel that I cannot breathe: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have been told that I toss & turn a great amount: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Immediately after falling asleep I dream: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have been told that I talk or scream in my sleep: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have been told that I grind my teeth in my sleep: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I wake up with a
sour stomach or an acid taste in my mouth: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I wake up with my heart beating irregularly: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I wake up at night
with muscular or joint aches and pains: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have the feeling of burning or
tingling in my legs or the feeling of restless legs: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I feel like I cannot move
after lying down, before going to sleep: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Do you take any medication to help you sleep? ❑YES ❑NO Medication_______________________

Patient Name______________________________________ **Date** ______________________

I see or hear things that
are not real when lying in bed but not asleep: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

After a typical night's sleep, I feel stiff or achy: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

After a typical night's sleep, I feel: ❑ Refreshed ❑ Fairly Rested ❑ Somewhat Tired ❑ Very Drowsy

I take naps: ❑ YES ❑ NO *If yes, how many per day?*_________ *Length of a normal nap:*_____________ *If no, reason you do not nap:* ❑ No Need ❑ No Time ❑ Situation Does Not Permit

I fight sleep uncontrollably for short periods of time while sitting:
❑ Always ❑ Frequently ❑ Occasionally ❑ Never
This occurs when (check all that apply):
❑ Watching TV ❑ During Meetings ❑ At the Movies ❑ Riding in a Car
❑ Other: ____

I fight sleep while driving a car?
❑ Always ❑ Frequently ❑ Occasionally ❑ Never *This last occurred when?*_______________
This primarily occurs (circle all that applies): ❑ Mornings ❑ Afternoons ❑ Evenings
I have fallen asleep while driving a car? ❑ YES ❑ NO
*If yes, how many times?*________________________________

I dream during my naps: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

After my naps I feel: ❑ Refreshed ❑ Fairly Rested ❑ Somewhat Tired ❑ Very Drowsy

I feel sudden weakness in my knees,
neck, jaw or arms when I get angry,
sad, while laughing or when I get emotional: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have episodes of doing strange things
without realizing it or losing periods of time: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Do you ever fall asleep uncontrollably when not tired? ❑ YES ❑ NO
Within the last year, depression, anxiety or stress has interfered with my sleep: ❑ YES ❑ NO
*If yes, please describe:*____

____

Is there a history in your family of sleep apnea? ❑ YES ❑ NO

I have been told that I quit breathing in the night: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

I have headaches in the morning: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Do you sleep in a recliner or elevated bed? ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Patient Name____ **Date** _______________________

Do you smoke or have you smoked? ❑ YES ❑ NO

If yes, how many years have (did) you smoke? ____________________________

If yes, how many cigarettes (cigars) per day? ____________________________

If you quit, how long ago? ____

Do you drink caffeinated beverages? ❑ YES ❑ NO

If yes, please circle beverage and indicate amount per day.

Coffee _________ Tea ____________ Soda _________ Other ___________

Do you consume Alcohol? ❑ YES ❑ NO

If yes, how often: ❑ Daily ❑ Weekly ❑ Monthly ❑ Annually

I usually drink in the: ❑ Morning ❑ Afternoon ❑ Evening

My usual beverage is: ❑Beer ❑Wine ❑Other_________________________

Amount: ____