Southwest Memorial Hospital Sleep Center
Phone: (970)564-2678 Fax: (970)565-2487
Office Hours 9:00am-5:00pm Monday-Thursday

ACCREDITED FACILITY MEMBER

SLEEP QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: M / F

Referring Physician: _____ Primary Care Physician: _____

Current Height: _____ Current Weight: _____

What was your weight: 1 year ago? _____ Five years ago? _____

Would you like to be contacted by email, if so enter your Email: _____

Please complete the following by filling in the blanks or placing a check mark in the appropriate areas when indicated.

Social History (Check all that apply to you):

☐ Sleep alone

☐ Share a bed with someone

☐ Share a bedroom, but have separate beds

☐ Share a dwelling, but have separate bedrooms

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Coffee: Amount _____ Within 2 hours of sleep _____

Tea: Amount _____ Within 2 hours of sleep _____

Energy Drinks: Amount _____ Within 2 hours of sleep _____

Soda: Amount _____ Within 2 hours of sleep _____

Smoker: ☐ No ☐ Never ☐ Quit, when _____ (i.e. 1995)

☐ Yes Packs per day _____ Years _____ (i.e. 10 years)

Alcohol: ☐ No ☐ Yes

If yes:

Beer	☐ Daily	☐ Rare	Within 2 hours of sleep _____
Wine	☐ Daily	☐ Rare	Within 2 hours of sleep _____
Liquor	☐ Daily	☐ Rare	Within 2 hours of sleep _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?
Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

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

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g., a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

(redrawn from Johns, MW, Sleep 1991, 14.40)

Epworth Sleepiness Scale Score: _____/24

		YES	NO
S	**Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?		
T	**Tired:** Do you often feel tired, fatigued or sleepy during the daytime?		
O	**Observed:** Has anyone observed you stop breathing during your sleep?		
P	**Blood Pressure:** Do you have or are you being treated for high blood pressure?		
B	**BMI:** BMI more than 35kg/m^2		
A	**Age:** Age over 50 years		
N	**Neck Circumference:** Neck Circumference greater than 40cm (15.7 inches)		
G	**Gender**: Are you a male?		
	TOTAL YES:		

STOP-BANG scoring model. Adapted from Chung F, et al. Anesthesiology2008; 108:812-21

Patient Name: _____DOB:_____

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MEDICATIONS

MEDICATION	**DOSEAGE** (MG, MCG, ETC)	**FREQUENCY** (Once a day, Twice a day, etc)	**TAKEN FOR:**

ALLERGIES

MEDICATION	**REACTION** (Rash, Shortness of Breath, etc)

Name: _____ DOB: _____

***My Main Sleep Complaint(s) Why** are you seeking evaluation at this time?*

☐ Trouble sleeping at night For how many months/years? _____

☐ Being sleepy all day For how many months/years? _____

☐ Snoring For how many months/years? _____

☐ My bed partner states I stop breathing when I sleep.

☐ Other, please explain: _____

Did you have sleep problems as a child? What were they?

_____

At what age do you remember having problems with your sleep start? _____

When was the last time you remember having a good night's sleep? _____

What do you think is causing your sleep problems? _____

_____

Sleep Pattern:

	Work Days (Weekdays)	**Off Days (Weekends)**
Typical Bedtime:	am/pm	am/pm
Typical amount of time it takes to fall asleep:		
Typical number of awakenings per night:		
Typical wake up time:	am/pm	am/pm
Desired wake up time:	am/pm	am/pm
How do you usually awaken (i.e. alarm clock)		
Typical time you get out of bed:	am/pm	am/pm
Number of naps per day:		
Length & time of naps:		
List any activities that you normally do during nighttime awakening(s): i.e. restroom, eat, watch TV:		

Sleep Habits (Check all that apply)

☐ I have trouble getting to sleep

☐ I have had *interrupted* sleep for several days

☐ I have difficulty initiating sleep

☐ I am unable to return to sleep easily if I wake up during the night

☐ At bedtime, I feel sad and depressed

☐ My sleep is disturbed by sadness or depression

☐ I usually watch TV or read in bed prior to sleep

☐ I drink alcohol prior to bedtime

☐ I smoke prior to bedtime or when I awaken during the night

☐ I sleep with someone else in my bed: ☐ People ☐ Pets ☐ Both

☐ I sleep with someone else in my room: ☐ People ☐ Pets ☐ Both

☐ I sleep with the following turned on in my room: ☐ TV ☐ Radio ☐ Computer ☐ Cell Phone ☐ Other

☐ I eat a snack at bedtime

☐ I wake up during the night and eat

☐ I wake up several times at night to go to the bathroom

☐ I sweat a great deal during sleep

☐ I cannot sleep on my back

☐ I fall out of bed while sleeping

☐ Wake up screaming, violent or confused.

☐ When falling asleep, I feel paralyzed (unable to move)

☐ I feel unable to move (paralyzed) after a nap

☐ I have dream-like images (hallucinations) when I awaken in the morning (even though I know I am not asleep)

☐ I see dream-like images (hallucinations) either just before or just after a daytime nap (yet I am sure I am awake when they happen)

☐ I am often unable to move (paralyzed) when I am waking up

☐ People notice that my jaw and/or face go slack when I laugh am surprised or have a strong emotion

☐ I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion.

☐ I have a lot of nightmares (frightening dreams)

☐ I have talked in my sleep as an adult

☐ I have walked in my sleep as an adult

☐ I grind my teeth in my sleep

☐ my desire or interest in sex is less than what it used to be

☐ Someone in my family has been hospitalized for a psychiatric illness or “nervous breakdown”

Daytime Sleepiness (check all that apply to you)

Do you feel refreshed when you awaken to start your day? ☐ Yes ☐ No

Do you have difficulty maintaining concentration during the day? ☐ Yes ☐ No

☐ I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long

☐ Now, I am very sleepy during the day and I struggle to stay awake

☐ I got bad grades in school because I was too sleepy

☐ I now have trouble doing my job because of sleepiness or fatigue

☐ I often have to let someone else drive the car because I am too sleepy to do it

☐ I have fallen asleep while driving

Does your job require you to drive ☐ Yes ☐ No
Number of close calls (auto accidents) due to sleepiness: _____
Number of auto accidents due to sleepiness: _____

☐ I tend to fall asleep during the day

☐ I take daytime naps

☐ I have had "blackouts" or periods when I am unable to remember what just happened

☐ I have had injuries as the result of sleepiness

Past Sleep Evaluation and Treatment:	**DATE**	**LOCATION**
☐ I have had a previous sleep disorder evaluation	____/_____/____	_____
☐ I have had previous overnight sleep studies	____/_____/____	_____
☐ I have had daytime nap studies	____/_____/____	_____

Have you ever had a night time oxygen study ordered by your doctor? ☐ Yes ☐ No

If yes, where and when?

_____

_____

_____

I have been prescribed a CPAP or bi-level (BiPAP) for home use:

☐ I use the CPAP or Bi-level (BiPAP) now with settings of _____.

☐ I do not use the CPAP or Bi-level (BiPAP) because _____.

☐ I have had surgical treatment for a sleep disorder.

☐ I have previously been prescribed medication for a sleep disorder: _____.

☐ I have previously been treated for a sleep disorder: _____.

Do you use:

Hearing aids?	☐ Yes	☐ No
Glasses?	☐ Yes	☐ No
Dentures?	☐ Yes	☐ No
Walker?	☐ Yes	☐ No
Wheelchair?	☐ Yes	☐ No

Do you require special assistance at night? ☐ Yes ☐ No

If yes, what type of assistance do you need: _____

_____

_____

Symptoms: (check all that have been a concern to you in the last months)

☐ Weight loss / gain	☐ Hoarseness	☐ Swelling in feet or ankles
☐ Chest pain, Tightness or Pressure	☐ Heartburn	☐ Irregular or rapid heartbeat
☐ Shortness of Breath	☐ Wheezing	☐ Frequent Headaches
☐ Headaches in the morning	☐ Incontinence	☐ Nocturia (up at night to bathroom)
☐ Syncope (fainting spells)	☐ Seizure	☐ Painful Joints or Muscles
☐ Nose Bleeds		
☐ Other:		

Other Medical Problems_____

_____

_____

_____

Past Surgical History_____

_____

_____

_____

PRINT Patient Name: _____

PATIENT Signature: _____

Date Form Completed: _____

Bed Partner Questionnaire:

Note: If you have a bed partner, please ask them to fill this part out for you.

Check any of the following behaviors that you have observed the patient doing while asleep:

☐ Light snoring	☐ Loud snoring	☐ Pauses in breathing
☐ Grinding teeth	☐ Biting tongue	☐ Becoming very rigid and/or shaking
☐ Twitching of legs or feet	☐ Kicking with legs	☐ Head rocking or banging
☐ Sleep talking	☐ Sitting up in bed while still asleep	☐ Getting out of bed while still asleep
☐ Sleep walking	☐ Bed wetting	

How long have you been aware of the sleep behavior(s) that you checked above? _____

_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night, and whether it occurs every night.

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

_____

Have you ever slept in another room because?

☐ Your bed partner kicks too much

☐ Your bed partner snores too loud

☐ Your bed partner makes unusual movements or acts out dreams

☐ Your bed partner keeps you awake by: _____

Name of person completing bed partner questionnaire: _____

Relationship to patient: _____

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