Austin Pulmonary

Austin Pulmonary Consultants

3600 W. Parmer ln
Ste 106
Austin Texas 78727

5920 W. William Cannon
Bldg 1 Ste 150
Austin Texas 7874

Sleep Questionnaire

Name: _____ Sex: _____ Age: _____ Date: _____

Date of birth: _____ Height:_____ Weight:_____ Neck size:_____

Referring Physician: _____ Primary Care MD: _____

MAIN SLEEP **COMPLAINT**(S)

❑ Trouble falling asleep ❑ Trouble remaining asleep

❑ Excessive sleepiness during the day

❑ Snoring

❑ Unwanted behaviors during sleep, such as _____

❑ Other, explain _____

❑ How long? _____

PRIOR SLEEP DISORDER DIAGNOSIS OR STUDIES

❑ I have a prior sleep diagnosis of _____

Prior sleep studies (where, when) _____

I am currently prescribed ❑ CPAP or ❑ Bilevel pressure. Settings _____

Oxygen during the ❑ day or ❑ night _____ liters per minute.

❑ Yes ❑ No I have had surgery for a sleep disorder ❑ UPPP ❑ Tonsillectomy.

❑ Other _____

❑ Yes ❑ No I use a dental device for sleep disor dered breathing.

SLEEP PATTERN

Typical bedtime: _____ weekday _____ weekend

Typical awakening time: _____ weekday _____ weekend

Typical hours in bed: _____ hours. Typical hours of sleep: _____ hours

Typical amount of time it takes to fall asleep _____ hours

Typical number of awakenings per night _____

Time it takes to fall back asleep after awakening _____

❑ Yes ❑ No I have a sleep pattern is irregular.

❑ Yes ❑ No I awaken early in the morning still tired but unable to return to sleep.

SLEEP ENVIRONMENT HABITS

Typical sleep position(s) ❑ back ❑ side ❑ stomach ❑ head elevated ❑ in a chair

❑ I sleep alone. ❑ I share a bed with someone.

My bedroom is ❑ comfortable ❑ noisy ❑ too warm ❑ too cold

❑ Yes ❑ No I have pets in the bedroom.

❑ Yes ❑ No I watch TV in bed prior to sleep.

❑ Yes ❑ No I read in bed prior to sleep.

❑ Yes ❑ No I work or study in bed.

❑ Yes ❑ No I drink alcohol prior to bedtime.

❑ Yes ❑ No I smoke prior to bedtime or when I awaken during the night.

❑ Yes ❑ No I eat a snack at bedtime.

❑ Yes ❑ No I eat if I awaken during the night.

BREATHING

❑ Yes ❑ No I have been told that I snore ❑ loudly.

❑ Yes ❑ No I have been told that I stop breathing while asleep.

❑ Yes ❑ No I have been told that I snore only when sleeping on my back.

❑ Yes ❑ No I have been awakened by my own snoring.

❑ Yes ❑ No I awaken at night choking or gasping for air.

❑ Yes ❑ No I awaken short of breath.

❑ Yes ❑ No I have trouble breathing when flat on my back.

❑ Yes ❑ No I have trouble breathing through my nose.

❑ Yes ❑ No I have morning headaches.

❑ Yes ❑ No I sweat a great deal at night.

DAYTIME SLEEPINESS

❑ Yes ❑ No I often feel drowsy during the day, more than I expect is normal.

❑ Yes ❑ No I feel unrefreshed or tired in the morning despite sleeping at night.

❑ Yes ❑ No I take I daytime naps. How many? _____

❑ Yes ❑ No I have uncontrollable urges to fall asleep during the day.

❑ Yes ❑ No I have experienced lapses in time or blackouts.

❑ Yes ❑ No I have fallen asleep while driving.

❑ Yes ❑ No I performed poorly in school or work because of sleepiness.

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate 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
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL (Range of 0 to 24)	_____

RLS

❑ Yes ❑ No I kick or jerk my legs excessively during sleep. ❑ This bothers my bed partner.

❑ Yes ❑ No I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.

❑ Yes ❑ No I experience an inability to keep my leg still prior to falling asleep.

❑ Yes ❑ No I experience the feeling of restlessness in my legs at night.

OREXIN RELATED

❑ Yes ❑ No I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise.

❑ Yes ❑ No I experience an inability to move while falling asleep or when waking up.

❑ Yes ❑ No I have experienced hallucinations or dreamlike images when falling asleep or waking up.

❑ Yes ❑ No I frequently dream during daytime naps.

PARASOMNIAS

❑ Yes ❑ No I act on my dreams while asleep.

❑ Yes ❑ No I have frequent nightmares.

❑ Yes ❑ No I talk in my sleep.

❑ Yes ❑ No I have sleep walked as an adult.

MISCELLANEOUS (Circadian, GERD, Depression, Enuresis, Bruxism, Pain)

❑ Yes ❑ No I frequently travel across two or more time zones.

❑ Yes ❑ No I am more alert in the morning than evening.

❑ Yes ❑ No I am more alert in the evening than morning.

❑ Yes ❑ No I awaken alert in the morning earlier than it is time to get up.

❑ Yes ❑ No I frequently have heartburn or acid reflux at night.

❑ Yes ❑ No I feel depressed.

❑ Yes ❑ No Chronic pain interferes with my sleep.

❑ Yes ❑ No The need to urinate frequently interrupts my sleep.

❑ Yes ❑ No I grind my teeth in my sleep.

❑ Yes ❑ No I have bedwetting (enuresis).

INSOMNIA

❑ Yes ❑ No I have trouble falling asleep.

❑ Yes ❑ No Thoughts start racing through my mind when I try to fall asleep.

❑ Yes ❑ No I have trouble remaining asleep.

❑ Yes ❑ No I awaken frequently during the night.

❑ Yes ❑ No I have difficulty returning to sleep if I awaken during the night.

HABITS

❑ Yes ❑ No I smoke cigarettes (or other tobacco). If yes, how much?

❑ Yes ❑ No I drink alcohol. If yes, how much and how often?

❑ Yes ❑ No I drink caffeinated beverages during the day _____cups/bottles/cans
❑ tea ❑ coffee ❑ soda per day

SOCIAL HISTORY

Marital status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment status: ❑ Employed: Occupation _____
❑ Unemployed ❑ Disabled ❑ Student ❑ Retired

❑ Yes ❑ No I regularly work night shifts.

❑ Yes ❑ No I work rotating shifts, including nice shiftwork.

PAST MEDICAL HISTORY

❑ Hypertension ❑ Coronary artery disease ❑ Congestive heart failure ❑ Stroke ❑ Seizures
❑ COPD/asthma ❑ Diabetes ❑ Cancer ❑ Thyroid problems ❑ Depression or anxiety
❑ Alcoholism or chemical dependency ❑ Sinus disease ❑ Allergic rhinitis/nasal congestion
❑ Nasal fracture ❑ Reflux (GERD) ❑ Stomach or colon problems ❑ Fibromyalgia
❑ Back or joint problems (arthritis)

❑ Other _____

Female ❑ Premenstrual syndrome ❑ Menopause

Male ❑ Prostate problems ❑ Erectile dysfunction

Prior surgeries _____

Weight change during the past year ❑ gained _____ pounds ❑ lost _____ pounds

CURRENT MEDICATIONS (OR ❑ LISTED ON SEPARATE SHEET)

Medication	Dose	Times Per Day

Allergies: _____

FAMILY HISTORY

Has an immediate blood relative had any of the following?

❑ Obstructive sleep apnea ❑ Narcolepsy ❑ Other sleep disorders? _____

_____