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? 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.")

_____

_____

_____

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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. <u>FAMILY HISTORY (Mother, Father, Siblings)</u>

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