Littleton Adventist Hospital Sleep Disorder Center
Patient Questionnaire

Please complete this questionnaire as accurately as possible. It will help in the evaluation and interpretation of your sleep study.

Name _____ Date _____ Height _____ Wt _____

Date of Birth _____Right or Left handed_____

Occupation _____ Altitude where you live _____

Primary Care Physician _____

MD who ordered the sleep study _____

Ear Nose & Throat MD (if applicable) _____

SLEEP HISTORY

My main sleep complaint(s) is/are: (*give duration of problem also)*

_____

_____

1. Have you been diagnosed with any problems listed below? *(check all that apply)*

___ Obstructive Sleep Apnea ___ Insomnia ___ REM Disorder

___ Narcolepsy ___ Restless Legs Syndrome

2. Have you ever had a sleep study before? Yes No
   If yes, when? _____ Where? _____

SLEEP SCHEDULE	Work Day	Day Off Work
Usual bedtime	_____pm/am	_____am/pm
Usual rise time	_____am/pm	_____am/pm
Total time in bed	_____hours	_____hours
Average time asleep	_____hours	_____hours
Average delay in falling asleep	_____min/hrs	_____min/hrs
Average number of awakenings	_____per night	_____per night
Time needed to fall back asleep	_____min/hrs	_____min/hrs

Patient Label

DAYTIME FUNCTION

1. Are you fatigued? Yes No
2. Is sleep refreshing to you? Yes No
3. Are you a restless sleeper? Yes No
4. Have you fallen asleep driving? Yes No
5. Have you come close? Yes No
6. Do you fall asleep at work? Yes No
7. Do you take any naps? Yes No
   How many times per week? _____
   How long are your usual naps? _____
   Are they refreshing? _____
8. Do your sleep problems affect your day to day life? Yes No
   If so, how? _____
   _____

SLEEP HYGIENE

1. Do you do any of the following in bed? *(check all that apply)*

   ___Eat ___Smoke ___Read ___Watch TV

2. Do you do any of the following? *(check all that apply)*

   ___ Eat a big meal immediately before sleep?

   ___ Do vigorous exercise immediately before sleep?

   ___ Take a hot bath or shower immediately before sleep?

3. Do you keep the same bedtime each night? Yes No
4. If you can't sleep, do you watch the clock to keep track of time? Yes No
5. Does your sleeping environment promote sleep (quiet, dark) Yes No
6. Do you feel stressed when going to sleep? Yes No
7. In what position do you sleep? *(check all that apply)*
   ___ Back ___Side ___Stomach ___Sitting Up
8. If and when you travel, is your sleep better or worse?
   ___Better ___Worse
   Explain: _____

SLEEP PROBLEMS

Please consult your bed partner as needed for help in answering the following questions. Answer as if you are describing a typical night.

Circle the appropriate frequency with which it occurs.

1. Do you snore?	Nightly	Weekly	Rarely	Never
2. Can your snoring be heard in another room?	Nightly	Weekly	Rarely	Never
3. Do you stop breathing while you sleep?	Nightly	Weekly	Rarely	Never
4. Do you wake up gasping?	Nightly	Weekly	Rarely	Never
5. Do you have a sore throat when you wake up?	Nightly	Weekly	Rarely	Never
6. Do you have a headache when you wake up?	Nightly	Weekly	Rarely	Never
7. When you are awake and either seated or lying down, do you have a creepy, crawly sensation in your legs?	Nightly	Weekly	Rarely	Never
8. Do these feelings interfere with falling asleep?	Nightly	Weekly	Rarely	Never
9. Do your legs twitch or kick while you sleep?	Nightly	Weekly	Rarely	Never
10. Do you talk in your sleep?	Nightly	Weekly	Rarely	Never
11. Do you eat in your sleep?	Nightly	Weekly	Rarely	Never
12. Do you walk in your sleep?	Nightly	Weekly	Rarely	Never
13. Do you grind your teeth at night?	Nightly	Weekly	Rarely	Never
14. Do you wake up confused at night?	Nightly	Weekly	Rarely	Never
15. Do you act out your dreams?	Nightly	Weekly	Rarely	Never
If yes, have you hurt yourself or someone else?	Yes	No		
16. Do you think you have insomnia?	Yes	No		
17. Do you have a hard time falling asleep?	Nightly	Weekly	Rarely	Never
18. Do you have a hard time staying asleep?	Nightly	Weekly	Rarely	Never
19. Does strong emotion cause any part of your body to become weak or limp?	Nightly	Weekly	Rarely	Never
20. Do you have hallucinations when you fall asleep or when you wake up?	Nightly	Weekly	Rarely	Never
21. Do you ever feel a sensation of paralysis when your mind is awake but your body remains asleep?	Nightly	Weekly	Rarely	Never

Patient Label

22. Do you have sudden irresistible urges to sleep? Nightly Weekly Rarely Never

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose 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 television	_____
Sitting inactive in a public place (theatre, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Patient Label

HABITS

1. How many cups of caffeinated beverages do you drink per day? _____
2. Do you consume caffeine in the afternoon? Yes No
3. How many alcoholic beverages do you drink per week _____
4. Do you smoke cigarettes or use tobacco? Yes No
   If so, how many per day ____ for ___ years If you've quit, when? _____

FAMILY HISTORY

1. Does anyone in your family have any of the following? *(check all that apply)*
   ____ Narcolepsy ____Restless Legs ____Sleep Apnea

MEDICATIONS *(include supplements, homeopathic remedies, vitamins)*

Name and Dose	Name and Dose
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Drug Allergies *(include reaction)* _____

_____

Are you allergic to tape? Yes No If Yes, what type? _____

PAST HISTORY

1. Have you had any ear/nose/throat procedures? *(check all that apply)*
   _____ Removal of tonsils/adenoids When? _____
   _____ Deviated nasal septum repair When? _____
   _____ Uvula-palatal-pharyngoplasty (UPPP) When? _____
   _____ Laser uvuloplasty (LAUP) When? _____
   _____ Any other surgeries for sleep apnea? Yes No
   Describe _____

 Patient Label

PAST HISTORY ***(continued)***

2. Have you had or been treated for any of the following: *(Check all that apply)*

___ Hypertension (High Blood Pressure)	___ Stroke (CVA)
___ Coronary Heart Disease	___ Seizures/epilepsy
___ Congestive Heart Failure	___ Peripheral neuropathy
___ Peripheral Vascular Disease	___ Diabetes
___ Atrial Fibrillation	___ Fibromyalgia
___ Other irregular heart rhythms: Describe_____	___ GERD (gastroesophageal reflux disease)
___ Chronic Pain Where _____	Use extra oxygen? ___ L/min at rest ___ L/min w/exercise ___L/min w/sleep
___ Depression	___ Bipolar disorder
___ Thyroid Gland Disease overactive underactive	___ Anxiety
___ Pulmonary Hypertension	___ Memory loss
___ Asthma	___ Dementia
___ COPD	___ Parkinson's disease
___ Restless Legs Syndrome	___ Other _____

REVIEW OF SYSTEMS *(check all that apply)*

___ Nose bleeds

___ Sinus problems

___ Seasonal allergies

___ Menopause

___ Testosterone medication

___ Heartburn or acid reflux

___ Nighttime urination: #times/night ____

___ Impotence

___ Arthritis

___ TMJ problems

___ Other medical problems _____

Patient Label

Please use this space to describe or list any other problems or concerns you think may be relevant to the interpretation of your sleep study:

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

The Sleep Disorder Center team

Patient Label