Medical Office Building - Backus Hospital
330 Washington Street • Suite 440
Norwich, CT 06360
P: 860.886.0228 F: 860.823.1978

SLEEP QUESTIONNAIRE

Patient Information: Today's Date ______________________

Last Name ______________________ First Name ______________________

DOB ______________________ Sex ______________________

Street ______________________ Apt/Unit # __________

City ______________________ State __________ Zip __________

Home Phone ______________________ Work Phone ______________________

Height ______________ Weight ______________ Neck Size __________

Physician Information:

Referring Physician
(Please Print Full Name) ______________________________________

Address ______________ City ______________ State ________ Zip ________

Phone ______________________ Fax ______________________

~ We will send a copy of the sleep study to this physician ~

Insurance Information:

Primary Insurance ______________ ID# ______________ Group/ Plan # ______________

Subscriber ______________ Employer ______________ Authorization # ______________

Do you currently drive? Yes No ***(circle one)***

If Yes, what state is your driver's license held in? __________

Occupation: ____

Are you currently using CPAP? Yes No ***(circle one)***

If Yes, what is the name of your medical equipment company? ______________________

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Sleep Problems:

Please describe why you are here today:

____
____
____
____
____
____
____
____

General Sleep Information:

What time do you usually go to bed ______________________

How long does it usually take to fall asleep? ______________________

How many times do you wake up in a typical night? ______________________

What time do you usually wake up in the morning? ______________________

How many hours of sleep do you usually get? ______________________

Do you often wake up in the morning with a headache? Yes No

Do you usually fall asleep with the TV on? Yes No

Do you keep the TV on throughout the night? Yes No

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Night Time Symptoms:

1. Do you snore loudly at night?
   Yes No

2. Does a bed partner move out of the bedroom because of your snoring?
   Yes No

3. Do you ever stop breathing during your sleep?
   Yes No

4. Do you ever wake up choking?
   Yes No

5. Have you ever been unable to move shortly after going to sleep or when waking up?
   Yes No

6. Do your legs jerk when you sleep?
   Yes No

7. Do you sometimes have an urge to move your legs, often associated with uncomfortable leg sensations?
   Yes No

8. Do you get relief, at least temporarily, from the urge or leg sensations when you move?
   Yes No

9. Do your leg symptoms begin or get worse when you are resting or inactive?
   Yes No

10. Do your leg symptoms get worse in the evening or at night?
    Yes No

11. Do you walk or talk in your sleep?
    Yes No

12. Did you walk or talk in your sleep as a child?
    Yes No

13. Do you grind your teeth during sleep?
    Yes No

14. As an adult, have you ever wet the bed during your sleep?
    Yes No

15. How many times do you awaken at night to go to the bathroom?
    ____

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Daytime Symptoms:

1. Are you drowsy or sleepy during the day?
   Yes No
2. Does daytime sleepiness interfere with your work?
   Yes No
3. Have you fallen asleep while driving or eating?
   Yes No
4. How many naps (if any) do you take per day?
   ____
5. How long is your longest nap?
   ________ hrs. / mins.
6. Does a nap make you feel more alert?
   Yes No
7. Do you have vivid dreams during daytime naps?
   Yes No
8. Do you drink coffee, tea, cola, or take any caffeine to stay awake?
   Yes No
9. Do you ever fall or lose muscle strength while laughing?
   Yes No

Emotional:

Are you now, or have you in the past had serious depression? Yes No

Are you now, or have you in the past had major anxiety? Yes No

Is your sleep problem causing emotional problems? Yes No

Are you currently under stress because of work or family? Yes No

Do you find that your sleep problems have diminished your interest in sexual activities? Yes No

Additional Comments:

____

____

____

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Work Schedule:

Please write down your current work schedule. This should include any overtime and extra shifts worked

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In							
Time Out							

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time In							
Time Out							

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Sleep Diary

Week 1: (Please Print Clearly)

DAY/DATE:	**SUN**	**MON**	**TUES**	**WED**	**THUR**	**FRI**	**SAT**
Time that you woke up							
Time that you got out of bed							
Did you wake up **R**efreshed or **T**ired?	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Note number of naps taken throughout the day							
Duration of longest nap (in minutes)							
Time that you went to bed							
Approximate time that you fell asleep							
Number of times that you woke up during night							
Note any information affecting sleep for the day							

Week 2: (Please Print Clearly)

DAY/DATE:	**SUN**	**MON**	**TUES**	**WED**	**THUR**	**FRI**	**SAT**
Time that you woke up							
Time that you got out of bed							
Did you wake up **R**efreshed or **T**ired?	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Note number of naps taken throughout the day							
Duration of longest nap (in minutes)							
Time that you went to bed							
Approximate time that you fell asleep							
Number of times that you woke up during night							
Note any information affecting sleep for the day							

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Week 3: (Please Print Clearly)

DAY/DATE:	SUN	MON	TUES	WED	THUR	FRI	SAT
Time that you woke up							
Time that you got out of bed							
Did you wake up **R**efreshed or **T**ired?	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Note number of naps taken throughout the day							
Duration of longest nap (in minutes)							
Time that you went to bed							
Approximate time that you fell asleep							
Number of times that you woke up during night							
Note any information affecting sleep for the day							

Comments:

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Patient Name: ____ DOB: ____________________

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Epworth Sleepiness Scale

Last Name ______________________________ First Name ________________________________

DOB ____________________________________ Today's Date ______________________________

Use the following scale to chose the most appropriate answer for each of the following:

0 = would **NEVER** doze
1 = **SLIGHT** chance of dozing
2 = **MODERATE** chance of dozing
3 = **HIGH** chance of dozing

Sitting and reading .... _________

Watching TV .... _________

Sitting inactive in a public place (theater, meeting, etc.) .... _________

As a passenger in a car for an hour without a break .... _________

Lying down to rest in the afternoon when able .... _________

Sitting and talking to someone .... _________

Sitting quietly after a lunch without alcohol .... _________

In a car while stopped for a few minutes in traffic .... _________

TOTAL _________