PULMONARY PHYSICIANS
of norwich

SLEEP QUESTIONNAIRE

Patient Information:

Name: _____ DOB: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (If different):_____

Social Security Number: _____ Sex: _____M _____F

Home Phone: _____ Cell Phone: _____Other: _____

Occupation: _____Shift: _____

Do you currently drive? Yes___No___ If yes, what state is your driver's license issued? _____

Have you ever had a sleep study? Yes___ No___ If yes, where & when? _____

Are you currently using CPAP? Yes___ No___ If yes, what company is your machine from? _____

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

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

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Night Time Symptoms continued:

7. Do you sometimes have an urge to move your legs, often associated with uncomfortable leg sensation? 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 walk 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? _____

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

Additional Comments:

_____

_____

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EPWORTH SLEEPINESS SCALE

Name: _____ DOB: _____ Today's Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

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

0 = would **NEVER** dose
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 _____