St. Francis Sleep Disorder Center
Sleep / Medical Questionnaire

Date:_____ DOB:_____

Name:_____ #_____

Height:_____Current Weight:_____Current neck size:_____ in.

What is bothering you most about your sleep and how long have you had this?_____

_____

_____

Sleep hygiene

1. What time do you usually go to bed?
   WEEKDAYS_____AM/PM WEEKENDS_____AM/PM
2. What time do you usually get up in the morning?
   WEEKDAYS_____AM/PM WEEKENDS_____AM/PM
3. How long does it usually take you to fall asleep?_____ mins.
4. How many times do you wake up at night?_____
   a. Number of times to go to bathroom?_____
   b. What other reasons?_____
5. How long does it take you to go back to sleep?_____
6. How many hours of sleep do you get at night?_____

Sleep Apnea/ Sleepiness:

7. Do other people complain about your snoring? Yes No
8. Have you been told that your snoring is worse on your back? Yes No
9. How many nights a week do you snore?_____
10. Can your snoring be heard outside the bedroom? Yes No
11. Have you been told that you stop breathing or that there are silent periods with no snoring followed by a loud snort and or body jerk? Yes No
12. Have you awakened with shortness of breath or a choking feeling? Yes No
13. Do you have night sweats? Yes No
14. Do you have nasal stuffiness or congestion during sleep? Yes No
15. Do you have to get up to go to the bathroom during your sleep period? Yes No

16. Do you awaken with a headache? Yes No
    Where does it hurt? _____

17. Do you wake up at night? Yes No
    If yes, how many times? _____

18. What wakes you up? _____

    _____

19. Have you gained or lost weight in the last 6 months? _____

20. If not active do you fall asleep before lunch? Yes No

21. Do you fall asleep while active before lunch? Yes No

22. Are you sleepy after lunch? Yes No

23. Do you fall asleep in the afternoon if not active? Yes No

24. Do you fall asleep in the afternoon if involved in an activity? Yes No

25. Have you ever fallen asleep while driving? Yes No

26. Do you fall asleep at work or school? Yes No

27. Do you take naps after work or school? Yes No

Narcolepsy/ Cataplexy

28. When you get emotional (angry, sad, happy and laughing) do you feel weak, as if you might fall? Yes No

Hypnagogic hallucinations

29. Do you have vivid dreams? Yes No

30. Do you see things upon awakening or falling asleep that you can not tell if they are real or not? Yes No

Sleep paralysis

31. Do you feel unable to move upon wakening or falling asleep? Yes No

32. Have you ever had trauma to your head or loss of consciousness? Yes No

Periodic limb movement

33. Do you have leg cramps at bedtime? Yes No

34. Do you have crawling or achy feelings in your legs during the day or night, that makes you want to move them or walk on them? Yes No

35. If yes, is this feeling worse at night? Yes No

36. Have you been told that you move your arms or legs frequently during the night? Yes No

37. Are your bed covers in disarray in the morning? Yes No

38. After falling asleep have you ever been awakened by a sudden jerk? Yes No

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = 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 like a theater or meeting _____

As a passenger in a car for one hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car while stopped for a few minutes in traffic _____

_____ **TOTAL**

Parasomnias

39. Do you remember your dreams? Yes No

40. Do you have nightmares? Yes No

41. Have you ever seen shadows at your bed or heard sounds or voices when you were about to fall asleep? Yes No

42. Have you ever felt like you were floating above your bed, seeing yourself in bed? Yes No

43. Do you have persistent, repeating or violent dreams? Yes No

44. Have you ever been told that you act out your dreams by swinging your arms or yelling? Yes No

45. If yes, does this happen during the first part of the night or closer to morning? First part closer to morning

46. Have you ever hurt yourself or your bed partner associated with these movements? Yes No
47. Do you sleep walk? Yes No
48. Do you talk in your sleep? Yes No
49. If yes, can others understand what you are saying? Yes No
50. If yes, does the talking occur the first third of the night or the last third? First 1/3 Last 1/3
51. Do you awaken confused? Yes No
52. Have you ever awakened feeling panicked with your heart beating uncontrollably? Yes No
53. As a child did you ever have uncontrolled urination during sleep? Yes No
54. As an adult have you ever had uncontrolled urination during sleep? Yes No
55. Have you ever had a seizure? Yes No

Insomnia

56. Are you able to fall asleep within 15 minutes or less? Yes No
57. Do you wake up during the night and cannot go back to during sleep? Yes No
58. Do you wake up one or two hours early in the morning? Yes No
59. Do you have thoughts racing through your mind while trying to fall asleep? Yes No
60. Do you look at the clock frequently while trying to fall asleep? Yes No
61. Does anxiety keep you from falling asleep? Yes No
62. How MUCH stress do you have at the present time? None Some A lot
63. Do you have muscle tension that keeps you from falling asleep? Yes No
64. Do you experience pain during the day or night? Yes No
65. Do you have sore achy muscles or feel stiff when you awaken in the morning? Yes No
66. Have you taken sleeping pills in the last 4 weeks? Yes No

67. What do you do when you can't fall asleep or return to sleep? _____

_____

68. What pattern has your insomnia followed since its onset?
_____persistent _____ periodic _____seasonal

69. Were there any stressful life events related to the onset of these symptoms? Yes No

_____ death of a loved one _____ divorce

_____ retirement _____ medical problem

_____ emotional problem _____job stress

Bruxism

70. Do you have jaw pain in the morning? Yes No

71. Has anyone told you that you grind your teeth at night? Yes No

Reflux

72. Do you have a sour or acid taste in your mouth during sleep? Yes No

73. Do you have heartburn or chest pain during sleep? Yes No

74. Do you gag, choke, or cough during sleep? Yes No

Circadian rhythm

75. Do you have trouble waking up in the morning? Yes No

76. Would you rather go to bed later and sleep later? Yes No

77. If you go to bed early (8pm) do you get up early (3am)? Yes No

Work Schedule

78. What is your occupation? _____

79. Do you work shift work? Yes No

80. What hours do you work? _____

Habits

81. Do you use recreational drugs? Yes No

If yes, what kind? _____

If yes, how often? _____

82. Do you drink alcohol? Yes No

If yes, how much per day? _____

Number of days per week? _____

83. Do you smoke? Yes No

If yes, how long have you or did you smoke? _____

How many cigarettes per day? _____

If no, when did you quit? _____

84. Do you drink caffeinated beverages? Yes No

What type? _____

How much per day? _____

When is your last drink before bedtime? _____

Personal illness history

Put a check next to any symptoms/illnesses you may have experienced:

____ Congestive Heart Failure
____ Heart Attack
____ Arthritis or Rheumatism
____ Polio or Meningitis
____ Thyroid Disease
____ Drug/Alcohol Abuse
____ High or Low Blood Pressure
____ Nervous Breakdown
____ Concussion or Head Injury
____ Knocked Unconscious
____ Nasal or Sinus Surgery
____ Psychological Problems
____ Migraine
____ Diabetes
____ Cancer
____ Epilepsy
____ Tonsillectomy

DO YOU NOW HAVE, or HAVE YOU HAD WITHIN THE PAST YEAR?
(Put a check next to any symptom/illness you have experienced)

____ Frequent or Severe Headaches
____ Fainting Spells
____ Dizziness on Change of Position
____ Unconscious Spells
____ Blurred Vision
____ Double Vision
____ Spots Before eyes
____ Recurrent nose bleeds
____ Recurrent head colds
____ Sinus trouble
____ Hay fever
____ Persistent hoarseness
____ Difficulty swallowing
____ Enlarged glands
____ Recurrent sore throats
____ Angina
____ Chronic or frequent coughing
____ Shortness of breath while waking up at night
____ Shortness of breath upon exertion
____ Shortness of breath when lying down
____ Purple lips or fingers
____ High Blood Pressure
____ Swelling of hands, feet, or ankles
____ Leg cramps on walking or at night
____ Enlarged veins in legs
____ Recurrent stomach pain
____ Belching or heartburn
____ Heartburn is relieved by food or medication
____ Coughed up Blood
____ Chest pain

Medications

List your prescription and over the counter medications:

Medication	Dose	Frequency

Allergies: _____

_____

_____

Any other relevant information you want to provide: _____

_____

_____

_____

_____