



Clinical Sleep Disorders Questionnaire

Name _____ Age _____ Height _____
 Address _____ Sex _____ Weight _____
 Phone Number () _____ SSN # _____
 Date of Birth ____/____/____

Referring Physician: _____ Phone number: _____

Family Physician: _____ Phone number: _____

How did you hear about us? _____

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write in your own if one the choices does not apply. Please answer as completely as possible.

1. What is your main concern regarding your sleep? (Why did your doctor order a sleep study?):

2. What is the most you have ever weighed? _____
 What did you weigh 5 years ago? _____
 What did you weigh 1 year ago? _____

3. When did your sleep problem begin?
 (month and/or year) _____

4. Have you ever had a sleep study before? YES NO
 If yes, where was the test performed? _____
 When was the test performed? _____
 What were the results? _____

5. Please list your current medications: (use back of page for additional information if needed)

MEDICATION	DOSE/FREQUENCY	LAST TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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6. My ideal amount of sleep is _____ hours per night.
During the week I usually: _____ During the weekend I usually: _____
go to bed at _____ (TIME) go to bed at _____ (TIME)
get up at _____ (TIME) get up at _____ (TIME)
sleep a total of _____ (HOURS) sleep a total of _____ (HOURS)
7. My job requires shift work: YES NO If yes, my hours are _____
8. It usually takes me _____ minutes to fall asleep.
9. I usually wake up _____ times during the night. Please explain what wakes you up:

10. I have difficulty going back to sleep once I wake up:
ALWAYS FREQUENTLY OCCASIONALLY NEVER
11. I snore:
ALWAYS FREQUENTLY OCCASIONALLY NEVER
12. My snoring started at age: _____
13. I snore in all sleeping positions: YES NO
14. My snoring has been described as: LIGHT MODERATE LOUD
15. I have problems with my nose or nasal breathing: YES NO
If yes, please explain: _____

16. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:
ALWAYS FREQUENTLY OCCASIONALLY NEVER
17. I have been told that I toss and turn to an extreme amount:
ALWAYS FREQUENTLY OCCASIONALLY NEVER
18. Immediately after falling asleep, I dream:
ALWAYS FREQUENTLY OCCASIONALLY NEVER

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19. I have been told that I talk or scream in my sleep:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

20. I have been told that I grind my teeth while I sleep:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

21. I wake up with a sour or stomach acid taste in my mouth:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

Last meal is eaten at what time? _____ a.m./ p.m.

22. I wake up with my heart beating irregularly:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

23. I wake up at night with muscle or joint aches and pains:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

24. I have the feeling of burning or tingling in my legs or the feeling of restless legs:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

25. I feel like I cannot move after lying down, before going to sleep:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

26. I see or hear things that are not real when lying in bed, but not asleep:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

Type of sound or visualization: _____

27. After a typical night's sleep, I feel stiff or achy:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

28. After a typical night's sleep, I feel:

REFRESHED FAIRLY RESTED SOMEWHAT TIRED VERY DROWSY

29. I take naps. YES NO If yes, how many per day? _____
If no, is there a reason why you do not take naps?

NO NEED

SITUATION DOES NOT PERMIT

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30. I fight sleep uncontrollably for short periods of time while sitting:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

This occurs when (circle each that applies):

Watching T.V. During Meetings At the Movies Riding in a Car

Other: _____

31. I fight sleep while driving:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

This last occurred when?: _____

This primarily occurs (circle the one that applies): Morning Afternoon Evenings

32. I have fallen asleep while driving a car: YES NO

If yes, how many times? _____

33. I dream during my naps:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

34. After my naps, I feel:

REFRESHED FAIRLY RESTED SOMEWHAT TIRED VERY DROWSY

35. I feel a sudden weakness in my knees, neck, jaw, or arms when I get angry, sad, while laughing or when emotional:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

36. I have episodes of doing strange things without realizing it or losing a period of time:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

37. Drowsiness is greatest in the: MORNING AFTERNOON EVENING

38. Within the last year, depression, anxiety, or stress has interfered with my sleep:

YES NO

If yes, please explain: _____

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39. Is there a history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring? _____

40. I have lost interest in sex or have trouble functioning sexually?

ALWAYS FREQUENTLY OCCASIONALLY NEVER

41. My spouse or bed partner has noticed that I quit breathing at night:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

42. I have headaches in the morning:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

43. Do you smoke or have you smoked? YES NO
If yes, how many years have (did) you smoked? _____
How many cigarettes (cigars) per day? _____
If you quit, how long ago? _____

44. Do you drink caffeinated beverages? YES NO
If yes, how many cups or cans per day? _____
My usual beverage is: COFFEE TEA SODA

45. I consume alcohol. YES NO
If yes, how often? DAILY WEEKLY MONTHLY
I usually drink in the: MORNING AFTERNOON EVENING
My usual beverage is: _____

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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, try to work out how they would have affected 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
1.	Sitting and reading	_____
2.	Watching television	_____
3.	Sitting inactive in a public place, (theater, meeting, etc.)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon when circumstances permit	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly after lunch without alcohol	_____
8.	In a car, while stopped, for a few minutes in traffic	_____
	Total Score	_____

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MEDICAL HISTORY:

Have you ever been diagnosed or treated by a physician for any of the following (**circle answers**):

		If yes, when?
Angina (heart pain/chest pain).....	NO	YES _____
Attention Deficit Disorder	NO	YES _____
Cardiac Arrhythmias (heart irregularities)	NO	YES _____
Chronic Lung Disease (asthma, bronchitis, emphysema,etc.).....	NO	YES _____
Congestive Heart Failure	NO	YES _____
Coronary Heart Disease (hardening of the arteries)	NO	YES _____
Depression	NO	YES _____
Deviated Nasal Septum.....	NO	YES _____
Diabetes	NO	YES _____
Edema (water retention)	NO	YES _____
Gastric Reflux (heart burn).....	NO	YES _____
Hay fever or allergic rhinitis.....	NO	YES _____
Hepatitis (please designate type below)	NO	YES _____
Hiatal Hernia.....	NO	YES _____
HIV	NO	YES _____
Hypertension (high blood pressure)	NO	YES _____
Hypothyroidism (low thyroid).....	NO	YES _____
Myocardial Infarction (Heart Attack).....	NO	YES _____
Nasal Polyps	NO	YES _____
Polycythemia (excessive red blood cells).....	NO	YES _____
Pulmonary Hypertension	NO	YES _____
Vocal Cord Disease (example: polyps)	NO	YES _____
Head and Neck surgery (tonsillectomy, deviated septum repair, etc.)	NO	YES _____

Past surgeries? If yes, what and when: _____

Known Drug Allergies: _____

I hereby authorize somniTech, Inc. to release the results of my study to any physician participating in my care or to the home health care agency designated by my physician to perform any follow-up care.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

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Observer / Bed partner Survey

Please have an observer or your bed partner complete this survey to help aid us in your sleep pattern evaluation. Thank you.

1. Briefly describe the individual's sleep problems. Indicate how long you have noticed these problems and how often do they occur.

2. Does he/she snore at night? _____

If yes, then please circle one:

A. **Loudly** or **Quietly**

B. **Sometimes** or **Continuously**

C. Is he/she mainly on their **back**, **side**, **stomach**, or **all the time**.

3. Does he/she appear to stop breathing at night or wakes up gasping? _____

If yes, then please circle one:

A. **Periodically** or **Frequently**

B. Is he/she mainly on their **back**, **side**, **stomach**, or **all the time**.

4. Does he/she kick often at night? **Yes** or **No**

If yes, explain: _____

5. Does he/she have trouble falling asleep at night? **Yes** or **No**

If yes, explain: _____

6. Does he/she fall asleep involuntarily during the day? **Yes** or **No**

If yes, explain: _____

7. Is it hard to wake him/her in the morning? **Yes** or **No**

If yes, explain: _____

8. Does he/she wake frequently at night? **Yes** or **No**

If yes, explain: _____
