

# Pulmonary and Sleep Medicine Center of Winder

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## Sleep Questionnaire for Adult Patients

Your answers to the following questions will help us to obtain a better understanding of your sleep problems. Please answer every question to the best of your ability. It is helpful to discuss the answers with someone who has witnessed your problems, such as a spouse or bed partner.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Please briefly describe your main sleep or sleep problem \_\_\_\_\_

When did your sleep problem begin? \_\_\_\_\_

### 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
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an 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	_____

## SLEEP SYMPTOMS

- |     |   |        |
|-----|---|--------|
| 1.  | Do you snore? .....   | YES NO |
|     | <i>How long have you been snoring? .....</i>  | _____  |
|     | <i>Is your snoring mild, moderate or loud? .....</i>  | _____  |
| 2.  | Are you sleepy while awake? ... ..  | YES NO |
|     | <i>How long have you been having this problem? .....</i>  | _____  |
| 3.  | Do you wake up gasping or feeling unable to breathe?.....   | YES NO |
| 4.  | Has your bed partner ever told you that you stop breathing during sleep? .....                            | YES NO |
| 5.  | Do you have a restless or creepy feeling in your legs?.....   | YES NO |
|     | <i>Is it worse at rest and in the evenings?.....</i>  | YES NO |
|     | <i>Is it temporarily relieved by moving your legs? .....</i>  | YES NO |
|     | <i>Does this prevent you from sleeping?.....</i>  | YES NO |
|     | <i>How often do you experience this problem in a week? .....</i>  | _____  |
| 6.  | Has your bed partner ever noticed leg movements or complained that you kick while you were sleeping?..... | YES NO |
| 7.  | Does your snoring or kicking prevent somebody from sleeping in the same bed with you?.....                | YES NO |
| 8.  | Do you get up more than once a night to urinate?.....   | YES NO |
|     | <i>If yes, how many times? .....</i>  | _____  |
| 9.  | Do you ever find yourself somewhere and do not know how you got there?.....                               | YES NO |
| 11. | Do you have vivid dreams shortly after falling asleep at night?.....                                      | YES NO |
| 12. | Do you ever feel that you cannot move after lying down or just after you awoken? .....                    | YES NO |
| 13. | Do you waken feeling refreshed? .....   | YES NO |
| 14. | Do you waken with a headache?.....  | YES NO |
| 15. | Do you have a problem with sleepiness while driving?.....   | YES NO |
| 16. | Have you ever had an automobile accident or near accidents related to sleepiness? .....                   | YES NO |

- How often?* ..... \_\_\_\_\_
- When was last time this happened?* ..... \_\_\_\_\_
17. Have you ever had accidents at work related to sleepiness?..... YES NO
18. Do you awaken during the night and have trouble going back to sleep?..... YES NO
19. Does your job require working different shifts?..... YES NO  
*If yes, which shifts?* \_\_\_\_\_
20. How do you sleep away from home (e.g., on vacation)? (Better, worse, or same)
21. Do you have trouble going to sleep? YES NO
22. Do you toss and turn in bed? ..... YES NO
23. Do you have frequent awakenings during the night? ..... YES NO
24. Do you awaken during the night and have trouble going back to sleep? ..... YES NO
25. Do you awaken at night with thoughts racing through your mind? ..... YES NO
26. Do you fall asleep more easily on the couch than in bed?..... YES NO
27. Do you feel frustrated or tense when seeing your bed or bed or bedroom? ..... YES NO
28. Do you have difficulty falling asleep or awaken frequently through the night because of pain? ..... YES NO
29. Do you awaken early in the morning and cannot go back to sleep? ..... YES NO
30. Have you felt depressed recently? ..... YES NO
31. Are you easily awakened by noise or light? ..... YES NO
32. Have you been having any marital conflict lately?..... YES NO
33. Do you have very much job stress? ..... YES NO
34. Do you find it difficult to get out of bed in the morning? ..... YES NO
35. Is your job or school performance affected by you sleep problem? ..... YES NO
36. Do you sleep talk?..... YES NO
37. Do you sleep walk? ..... YES NO
38. Do you eat when you wake up at night? ..... YES NO  
*Do you remember that in the morning?* ..... YES NO

39. Have been told that you act your dreams? ..... YES NO
40. Have you ever hurt yourself or bed partner while asleep? ..... YES NO
41. Do you grind your teeth at night? ..... YES NO
42. Have you had any sleep problems as a child or teenager? ..... YES NO
- If yes, please describe: .....*
43. Has your weight changed?..... YES NO  
 If yes: Up or down?\_\_\_\_\_How much?\_\_\_\_\_Over how long?\_\_\_\_\_
44. While awake, do you experience short of breath or wheezing?..... YES NO
45. Have you ever been treated for snoring, sleep apnea, sleepiness  
 or insomnia? ..... YES NO
46. Have you ever had a sleep study? ..... YES NO
- If yes, where, when, what did it show?\_\_\_\_\_
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**SLEEP HABITS**

- |   | <u>Work Days</u> | <u>Weekends</u> |
|---|------------------|-----------------|
| a) What time do you go to bed?  | _____ am/pm      | _____ am/pm     |
| b) What time do you get up?   | _____ am/pm      | _____ am/pm     |
| c) On average, how many times do you wake-up during the night?  | _____            | _____           |
| d) How long does it take you to fall asleep?  | _____ min        | _____ min       |
| e) If awoken, How long does it take you to fall back to sleep   | _____ min        | _____ min       |
| f) On average, how many hours of actual sleep do you get nightly?   | _____ hrs        | _____ hrs       |
| g) What time do you go to work or school?   | _____ am/pm      | _____ am/pm     |
| h) What time do you return home?  | _____ am/pm      | _____ am/pm     |
| i) Naps:  |                  |                 |
| <i>Number of day time naps</i> _____ <i>Duration</i> _____  |                  |                 |
| <i>Number of evening naps</i> _____ <i>Duration</i> _____   |                  |                 |
| j) Please list your activities in bed, (TV, reading, eating, computer, video games.)_____                                       |                  |                 |
| k) Please list what you do if you wake up at night and can't go back to bed (TV, reading, eating, computer, video games.)._____ |                  |                 |

Are your sleep habits on the weekends similar to weekdays? ..... YES NO

**MEDICAL HISTORY:** Have ever been told by a doctor that you have:

- |     |                                    |     |  |
|-----|------------------------------------|-----|--|
| YES |                                    | YES |  |
| [ ] | Hypertension (high blood pressure) | [ ] | Depression or other psychiatric disorder |
| [ ] | Thyroid gland problems             | [ ] | Irregular heart beat                     |
| [ ] | PTSD/panic attacks                 | [ ] | Heartburn/Reflux disease                 |
| [ ] | Epilepsy/seizures                  | [ ] | Emphysema or Chronic Bronchitis          |
| [ ] | Heart attack                       | [ ] | Asthma                                   |
| [ ] | Pain disorder                      | [ ] | Fibromyalgia                             |
| [ ] | Angina                             | [ ] | Sinusitis                                |
| [ ] | Stroke                             | [ ] | High cholesterol                         |
| [ ] | Diabetes                           | [ ] | Cancer                                   |

Please list any other medical problems here:

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**SURGICAL HISTORY** Have you ever had:

- |     |                                   |     |                               |
|-----|-----------------------------------|-----|-------------------------------|
| YES |                                   | YES |                               |
| [ ] | Tonsillectomy (tonsils taken out) | [ ] | Hysterectomy                  |
| [ ] | History of trauma                 | [ ] | Cholecystectomy (gallbladder) |
| [ ] | Appendectomy                      | [ ] | other surgeries _____         |

**Medication list**

**List medications (including the ones you can get without a prescription):**

<u>Name</u>	<u>Dose</u>	<u>Name</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you ever use sleep pills, tranquilizers or sedatives?

Yes No If yes, please list.

<u>Name</u>	<u>Dose</u>	<u>Name</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies**

Please list all drugs that you are allergic to and the type of reaction:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY**

Yes No Does anyone in your family snore or been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorder? If yes, please list: \_\_\_\_\_

Yes No Has anyone in your family been diagnosed with one of the disorders listed under the medical history above? If yes, please list: \_\_\_\_\_

**SOCIAL HISTORY**

**Habits**

Do you smoke? Present Past Never  
If present smoker: packs/day \_\_\_\_\_ years \_\_\_\_\_  
If past-smoker: packs/day \_\_\_\_\_ years \_\_\_\_\_ when quit? \_\_\_\_\_

How much of the following do you use:

	CURRENT	
	<u>Weekdays</u>	<u>Weekend days</u>
Coffee	_____	_____
Tea	_____	_____
Chocolate	_____	_____
Caffeinated soda (pop)	_____	_____
Alcohol	_____	_____
Recreational drugs	_____	_____

Please list with whom you live: \_\_\_\_\_

Occupation(s):  
Past \_\_\_\_\_  
Present \_\_\_\_\_

**Review of System**

Are you currently or regularly experience any of the following symptoms?

(Please check all that apply)

**GENERAL**

Fatigue [ ] yes [ ] no  
Fever [ ] yes [ ] no  
Loss of appetite [ ] yes [ ] no  
Weight gain [ ] yes [ ] no  
Weight loss [ ] yes [ ] no

**HEENT**

Blurred vision [ ] yes [ ] no  
Nasal/seasonal allergies [ ] yes [ ] no  
Change in voice [ ] yes [ ] no  
Frequent nosebleed [ ] yes [ ] no  
Hearing loss [ ] yes [ ] no  
Sinus pain [ ] yes [ ] no  
Sore throat [ ] yes [ ] no

**CARDIOLOGY**

Supine shortness of breath [ ] yes [ ] no  
Chest pain [ ] yes [ ] no  
Palpitations [ ] yes [ ] no

**RESPIRATORY**

Wheezing [ ] yes [ ] no  
phlegm production [ ] yes [ ] no  
Cough [ ] yes [ ] no  
Shortness of breath [ ] yes [ ] no

**GASTROENTEROLOGY**

Abdominal pain [ ] yes [ ] no  
Blood in stool [ ] yes [ ] no  
Constipation [ ] yes [ ] no  
Heartburn [ ] yes [ ] no  
Diarrhea [ ] yes [ ] no

**MUSCULOSKELETAL**

Back pain [ ] yes [ ] no  
Joint pain [ ] yes [ ] no

**DERMATOLOGY**

Suspicious moles [ ] yes [ ] no  
Change in color [ ] yes [ ] no  
Rash [ ] yes [ ] no

**ENDOCRINOLOGY**

Cold intolerance [ ] yes [ ] no  
Excessive sweating [ ] yes [ ] no  
Excessive thirst [ ] yes [ ] no  
Heat intolerance [ ] yes [ ] no

**HEMATOLOGY/LYMPH**

Easy bruising [ ] yes [ ] no  
Swollen glands [ ] yes [ ] no

**NEUROLOGY**

Dizziness [ ] yes [ ] no  
Fainting spells [ ] yes [ ] no  
Headache [ ] yes [ ] no  
Memory loss [ ] yes [ ] no  
Seizures [ ] yes [ ] no

**PSYCHIATRIC**

Anxiety [ ] yes [ ] no  
Depression [ ] yes [ ] no  
Hallucinations [ ] yes [ ] no

**UROLOGY**

Blood in urine [ ] yes [ ] no  
Difficulty urinating [ ] yes [ ] no  
Urinary incontinence [ ] yes [ ] no

