Community HOSPITAL

Sleep Lab
Sleep Questionnaire

Name____ Date____________________

Fill out with the help of your spouse or relative – if applicable.

1. My snoring is: ____ Very loud every night, all night
   ____ Every night, not constant, not always loud
   ____ Occasional/mild
   ____ I Never/ or almost never snore

2. Do you and your spouse commonly sleep in different rooms due to snoring? ____Yes ____No

3. How many years have you snored? ________

4. Has anyone noted pauses in your breathing (apnea) during sleep? ____Yes ____No

   (Check one) If yes: ____ Repetitively, all night, every night
   ____ Some pauses of breathing (apnea) every night
   ____ Occasional pauses of breathing (apnea), not every night

5. Do you awaken with a headache? ____ Sometimes
   ____ Commonly
   ____ No

6. Do you nap daily? ____ Yes ____ No

7. How likely are you to dose off or fall asleep in the following situations, in contrast to feeling just tired? Think about these situations in your day to day life in the past 6 months. Even if you have not been in some of these situations recently, think about how they might have affected you in the past. Use the following scale to choose the most appropriate number for each situation:

Scale:

0 = Would ***never*** dose
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 theatre or a meeting)	____________
As a passenger in a car for an hour without 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 the traffic	____________

8. On a scale of 1 – 10 (1 not being tired at all and 10 being exhausted during the day), what number would best describe your average daytime tiredness or sleepiness? ______________

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9. Driving: ____Yes ____No Do you often get drowsy?
____Yes ____No Have you occasionally nodded off or closed your eyes for a fraction of a second?
____Yes ____No Have you drifted out of your lane from dozing?
____Yes ____No Have you had a car accident from falling asleep?

10. Have you ever had a significant nasal injury (sports activities, fist fights, opening door, etc.)? ___Yes ____No

11. Do you have nasal allergies/hay fever? ____Yes ____No

12. Do you sometimes awaken with one nostril or the other plugged up? ____Yes ____No

13. What is your present weight? _______lbs. 5 years ago?_______lbs. 10 years ago?_______lbs.

14. Have you ever had a thyroid function blood test? ____Yes ____No

15. How many hours, on the average, do you sleep per night? _____hrs

16. What is your usual bedtime? _______ Usual awakening time? _______

17. How many additional awakenings do you have on an average night? _______

What awakens you? (Check all that apply):

____Need to void (urinate)
____Shortness of breath
____Noise of snoring
____Don't know
____Other____
____Not applicable to me

Do you have difficulty falling back to sleep?
____Yes ____No

18. Do your legs twitch as you are drifting off to sleep? ____Yes ____No

19. Do you need to get up and walk to stretch and move your legs at night? ____Yes ____No

20. Do you have heartburn or acid taste in your throat at night? ____Always ____Sometimes ____Never

21. Have you heard a voice speaking or seen things like visions or dreams, as you fall asleep or upon awakening?
____Yes ____No

22. Have you felt paralyzed or unable to move, though mentally alert, as you fall asleep or upon awakening?
____Yes ____No

23. Have you had episodes of instant muscle weakness (knees buckle, jaw drops, falls, near falls, or voice slurs) brought on by laughter, humor, anger or excitement? ____Yes ____No

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24. What is your average number of cups per day of: Coffee/tea______
Cola drinks______
Alcohol______

25. Do you take at night: ____Yes ____No Sedative/nerve pills?
____Yes ____No Sleeping pills?
____Yes ____No Antidepressant pills?

26. Do you exercise regularly? ____Yes ____No
What form of exercise?______________________________________
Minutes per day________
Times per week________

Family History

Check if any blood relative has or has had any of the following:

___Stroke
___High blood pressure
___Diabetes
___Asthma
___Emphysema
___Lung cancer
___Heart disease
___Narcolepsy
___Loud snoring
___Sleep apnea
___Restless leg syndrome

Past History (personal)

Have you had any of the following illnesses? **(Check all that apply)**

___Angina pectoris
___Heart attack
___Other heart disease
___High blood pressure
___Kidney disease
___Hay fever
___Asthma
___Frequent lung infections
___Emphysema
___Diabetes
___Cancer
___Frequent bladder infections
___Nervous breakdown
___Thyroid disease
___Stomach ulcers
___Hepatitis
___Colitis
___Arthritis
___Depression
___Suicidal thoughts or attempts
___Other:_______________

Operations, Hospitalizations, and Serious Injuries:

List and indicate approximate year

____
____
____
____
____
____
____
____

Are you allergic to any medications? ___Yes ___No

If yes, please list medications and the reaction you had to them:

____
____

Last chest X-ray: _______________

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Medications

What medications do you currently take:

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

Occupation **(please list by dates)**:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Please list the places where you have lived

_______________________________ _______________________________
_______________________________ _______________________________

Pulmonary

1. What is the main problem you are being tested for? _______________________________

2. Do you use oxygen? ___Yes ___No

   How much?_________________ Date started?_________________

3. Do you smoke? ___Yes ___No

   ___Cigarettes ___Pipe ___Cigars

   If no, have you ever smoked?________How many cigarettes per day?_________________

   How old when you began?__________When did you stop smoking?___________________

___Yes ___No Do you have chest pain?
___Yes ___No Do you wheeze?
___Yes ___No Do you cough?
___Yes ___No Do you cough up phlegm? For how many years?____________
___Yes ___No Do you have shortness of breath?
___Yes ___No Have you coughed up blood in the past year?
___Yes ___No Have you ever had pneumonia? When?_______________
___Yes ___No Have you ever had special tests or operations performed on your lungs, chest or heart?
___Yes ___No Do you have allergies or sinus problems?
___Yes ___No Have you ever applied for, or are you receiving disability for lung or heart disease?
___Yes ___No Do you use petroleum jelly products in your nose – like Vicks or Mentholatum?
___Yes ___No Do you have heartburn or symptoms of stomach acid reflux?
___Yes ___No Do you snore?
___Yes ___No Have you ever had blood clots in your legs or lungs?
___Yes ___No Do you have swelling of feet or ankles?

What is your normal weight?________lbs. What is your normal height?__________________

About how far can you walk on a level surface (street, path)?______________________

____