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. What percent of the night do you sleep on your back? _____

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

Past History (personal)

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

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

_____