Tallahassee Memorial Sleep Center Patient Questionnaire

Name _____ Age _____ Date _____

Date of Birth _____ Sex _____ Height _____ ft _____ in Weight_____ lbs

Neck size _____ inches (If known) Body Mass Index (BMI) _____ **(**If known)

Phone(s) _____(home) _____(work) _____(cell)

Referring Doctor_____ Primary Care Doctor_____

Have you had a previous sleep study? ☐Yes ☐No

If yes, what sleep center was it done at? _____

WHAT SLEEP PROBLEM(S) ARE BOTHERING YOU. CHECK THE BOXES BELOW.

_____

_____ How long has this problem bothered you? _____

Check all that apply to you and your sleep. To the right of each problem, list how long this has bothered you?

☐ Loud snoring	____ years	☐ Difficulty falling asleep	____ years
☐ Excessive daytime sleepiness	____ years	☐ Restless legs, usually at night	____ years
☐ Excessive daytime fatigue	____ years	☐ Wake up frequently during the night	____ years
☐ Non-refreshing sleep	____ years	☐ Wake up early in the morning	____ years

PLEASE RATE HOW OFTEN YOU: CIRCLE ALL THAT APPLY

	Never (N)	Rarely (R)	Sometimes (S)	Frequently (F)	Constantly (C)
Do you snore	N	R	S	F	C
Snore so loudly that others complain	N	R	S	F	C
Snore so loudly that spouse sleeps in different room	N	R	S	F	C
Suddenly wake up gasping for breath	N	R	S	F	C
Others say that you stop breathing during your sleep	N	R	S	F	C
Fall asleep watching TV or sitting on the couch	N	R	S	F	C
Fall asleep reading a book or magazine	N	R	S	F	C
Fall asleep at school or at work (e.g. at computer)	N	R	S	F	C
Fall asleep involuntarily	N	R	S	F	C
Almost fallen asleep driving and veered off the road	N	R	S	F	C
Had a motor vehicle accident due to falling asleep	N	R	S	F	C
Feel tired during the day, especially after lunch	N	R	S	F	C
Feel refreshed when you wake up	N	R	S	F	C
Feel like you get a good night's sleep	N	R	S	F	C
Experience sudden attacks of muscle weakness when laughing, crying, or being highly emotional	N	R	S	F	C
Feel unable to move when half-awake and laying in bed (paralyzed when falling asleep or waking up)	N	R	S	F	C
Have vivid dream-like scenes while falling asleep (hypnagogic hallucinations)	N	R	S	F	C
Have vivid dreams within a few minutes of falling asleep (hypnagogic dreaming)	N	R	S	F	C

	Never (N)	Rarely (R)	Sometimes (S)	Frequently (F)	Constantly (C)
Remember your dreams	○N	○R	○S	○F	○C
Act out your dreams	○N	○R	○S	○F	○C
Talk in your sleep	○N	○R	○S	○F	○C
Walk in your sleep	○N	○R	○S	○F	○C
Eat in the middle of the night and are unaware of it	○N	○R	○S	○F	○C
Grind your teeth in your sleep	○N	○R	○S	○F	○C
Experience creepy, crawling, aching feelings in both legs or simply have leg pains	○N	○R	○S	○F	○C
Have an urge to move legs associated with leg discomfort or leg pain	○N	○R	○S	○F	○C
This leg discomfort worsens at night	○N	○R	○S	○F	○C
This leg discomfort worsens at rest or when inactive	○N	○R	○S	○F	○C
This leg discomfort is relieved by movement	○N	○R	○S	○F	○C
Experience nocturnal leg jerking	○N	○R	○S	○F	○C
Have indigestion or esophageal reflux at night	○N	○R	○S	○F	○C
Awaken with chest pain	○N	○R	○S	○F	○C
Awaken from sleep short of breath	○N	○R	○S	○F	○C
Sweat excessively during the night	○N	○R	○S	○F	○C
Have trouble sleeping when you have a cold	○N	○R	○S	○F	○C

GENERAL SLEEP HABITS

1. On average, how many hours of actual sleep do you get per night?_____

2. What time do you usually go to bed on the WEEKDAYS?_____WEEKENDS?_____

   What time do you usually wake up on the WEEKDAYS?_____ WEEKENDS?_____

3. On average, how long does it take you to fall sleep without a sleep aid?_____ With a sleep aid?_____

4. When you are asleep or trying to fall asleep, are you often disturbed by:

   ☐ Racing thoughts ☐ Restless legs ☐ Pain ☐ Bed Partner ☐ Light
   ☐ Anxiety ☐ Night sweats ☐ Heat ☐ Pets ☐ Noise
   ☐ Headaches ☐ Esophageal reflux ☐ Cold ☐ Not being in your usual bed

   Other_____

5. How many times do you typically wake up at night?_____

   How many of these times is it because you needed to urinate?_____

   On average, how long does it take you to fall asleep after each awakening?_____

6. On average, how long do you stay in bed after waking up in the morning?_____

7. Do you work evening shift, night shift, split shifts, or rotating (variable) shifts?_____

   If so, what is your schedule?_____

8. Do you usually: (Check all that apply)

   ☐ Sleep with someone else in your bed
   ☐ Sleep with someone else in your room
   ☐ Provide assistance to someone during the night (child, invalid, bed partner, animal)

9. Do you wear a dental device when sleeping? If Yes, is it for sleep apnea _____ or teeth grinding_____?

   If so, please provide dentist's name:_____

10. Do you sleep on more than two pillows: ☐ Yes ☐ No Please check if you have an adjustable bed: ☐ Yes

11. How many cups of coffee, tea, or other caffeinated beverages do you drink in 1 day?_____

12. What time do you usually drink your last cup of a caffeinated beverage?_____

13. Do you usually drink coffee or tea within 2 hours before going to bed? ☐ Yes ☐ No

14. Do you do physical exercise before going to bed? ☐ Yes ☐ No

15. Do you read before falling asleep? ☐ Yes ☐ No

16. Do you take naps during the afternoon or evening? ☐ Never ☐ Seldom ☐ Frequently

17. Do you feel refreshed after a short (10-15 minute) nap? ☐ Yes ☐ No

18. How do you feel after an average night of sleep? ☐ Drowsy/Tired ☐ Usually I feel good ☐ Consistently I feel good

19. If you feel drowsy or tired after an average night of sleep, how long do you feel this way?_____

20. Do you feel better during the? ☐ Morning ☐ Afternoon ☐ Night

21. How much weight have you gained in the last year?_____ lbs Since the age of 18?_____ lbs

PAST MEDICAL HISTORY

Check all that apply:

☐ High Blood Pressure	☐ Esophageal Reflux/Hiatal hernia	☐ Seizures/Epilepsy	☐ Osteoarthritis
☐ Diabetes	☐ Sinus Allergies/Hay fever	☐ Parkinson's Disease	☐ Rheumatoid arthritis
☐ Heart Disease/Heart Attack	☐ Asthma	☐ Dizzy/Blackout Spells	☐ SLE (Lupus)
☐ Congestive Heart Failure	☐ COPD (emphysema)	☐ Chronic back pain	☐ Osteoporosis
☐ Heart murmur	☐ Pregnancy	☐ Chronic neck pain	☐ Depression
☐ Atrial fibrillation	☐ HIV/AIDS	☐ Chronic pain syndrome	☐ Bipolar disorder
☐ Stroke	☐ Hypothyroidism	☐ Fibromyalgia	☐ ADD or ADHD
☐ Elevated cholesterol	☐ Strep throat before 21 years old	☐ Mononucleosis (Mono)	☐ Kidney Disease
☐ Cancer_____	☐ Cancer_____	☐ Other_____	☐ Liver Disease
Type of cancer	Type of cancer	☐ Other_____	

ENT Surgery or Surgery for Sleep Apnea:

☐ Tonsillectomy	☐ Adenoidectomy	☐ UPPP	☐ LAUP
☐ Nasal surgery	☐ Nasal septoplasty	☐ Turbinate reduction	☐ Sinus surgery

Other_____

Surgery:

☐ Gallbladder	☐ Appendectomy	☐ Hysterectomy	☐ Mastectomy
☐ Heart bypass surgery	☐ Hernia surgery	☐ Ovaries removed	☐ Back surgery
☐ Gastric bypass surgery	☐ Joint Replacement_____	_____	
	Joint Replaced and Year	Joint Replaced and Year	

☐ Other surgery_____

☐ Any complications related to anesthesia or surgery?_____

Vaccinations:

Pneumonia Vaccine (Pneumovax) ☐ No ☐ Yes Date last given_____

Flu Vaccine ☐ No ☐ Yes Date last given_____ Ever had swine flu vaccine? ☐ No ☐ Yes

Usual Childhood Vaccines (if applicable) ☐ No ☐ Yes

MEDICATIONS

Drug	Dose	Frequency	Purpose

ALLERGIES

Medication	Reaction	Medication	Reaction
_____		_____	
_____		_____	
_____		_____	

LANGUAGE/LEARNING

Preferred Learning Method: ____ Auditory ____ Visual _____ Written _____ Documentation
Preferred Language for Learning: ____ English ____ Other

SOCIAL HISTORY

1. Have you ever smoked cigarettes? ☐ Yes ☐ No
2. How much did you smoke?_____ How many years?_____
3. If you have quit smoking, how many years ago did you quit?_____years ago
4. Do you drink alcohol? ☐ Yes ☐ No
5. What do you drink? ☐ Beer ☐ Wine ☐ Liquor
6. How many alcoholic drinks do you have? _____per day _____per week _____per month
7. Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
8. What is your occupation?_____
9. Is your present work situation satisfactory?_____ Is your present social life satisfactory?_____
10. Has your sleep problem required you to cut back on social activity?_____
11. Does your sleep problem disturb your sex life?_____
12. With whom are you living with now? (wife, husband, children, parents, etc. and their ages)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

1. Father's Medical Problems _____

   Cause of Death _____ Age at death _____ years old

2. Mother's Medical Problems _____

   Cause of Death _____ Age at death _____ years old

3. Does any other member of your family have other medical problems? Please list.

   Relative _____ Problems _____

   Relative _____ Problems _____

   Relative _____ Problems _____

   Relative _____ Problems _____

4. Does any other member of your family have sleep apnea or other sleep problems? Please explain.

   Relative _____ Sleep Problems _____

   Relative _____ Sleep Problems _____

Epworth Sleepiness Scale

Name: _____ Today's Date: _____

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 below:

0 = would *never* doze 1 = *slight* chance of dozing

2 = *moderate* chance of dozing 3 = *high* chance of dozing

Make sure you circle a number for each situation.

SITUATION	CHANCE OF DOZING
1. Sitting and Reading	○0 ○1 ○2 ○3
2. Watching Television	○0 ○1 ○2 ○3
3. Sitting inactive in a public place (e.g., a theater or meeting)	○0 ○1 ○2 ○3
4. As a passenger in a car for an hour without a break	○0 ○1 ○2 ○3
5. Lying down to rest in the afternoon when circumstances permit	○0 ○1 ○2 ○3
6. Sitting and talking to someone	○0 ○1 ○2 ○3
7. Sitting quietly after lunch without alcohol	○0 ○1 ○2 ○3
8. In a car, while stopped in traffic	○0 ○1 ○2 ○3
	TOTAL SCORE: _____

(Maximum = 24. Normal < 10)

Fatigue Severity Scale

This questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you. A low number indicates strong disagreement with the statement, whereas a high value indicates a strong agreement with the statement.

Make sure you circle a number for every statement.

During the past week, I have found that:	**Disagree----------Agree** **very much** **very much**
1. My motivation is lower when I am fatigued	○1 ○2 ○3 ○4 ○5 ○6 ○7
2. Exercise brings on my fatigue	○1 ○2 ○3 ○4 ○5 ○6 ○7
3. I am easily fatigued	○1 ○2 ○3 ○4 ○5 ○6 ○7
4. Fatigue interferes with my physical functioning	○1 ○2 ○3 ○4 ○5 ○6 ○7
5. Fatigue causes frequent problems for me	○1 ○2 ○3 ○4 ○5 ○6 ○7
6. My fatigue prevents sustained physical functioning	○1 ○2 ○3 ○4 ○5 ○6 ○7
7. Fatigue interferes with carrying out certain responsibilities	○1 ○2 ○3 ○4 ○5 ○6 ○7
8. Fatigue is among my three most disabling symptoms	○1 ○2 ○3 ○4 ○5 ○6 ○7
9. Fatigue interferes with my work, family, or social life	○1 ○2 ○3 ○4 ○5 ○6 ○7
	TOTAL SCORE: _____

(Maximum = 63. Normal < 36)