Crouse
MEDICAL PRACTICE, PLLC

Sleep Questionnaire

Name: _____ **Date:**_____

Date of Birth: ___/____/___ **Age:** _____ **Gender:** _____ **Height:** ____ **Weight:** _____ lbs.

Referring Physician: _____ **Occupation:** _____

Please give a brief description of your sleep problem and its duration:

_____
_____
_____

Please describe any events that occur while falling asleep, during sleep, or while waking up that you consider unusual:

_____
_____
_____

List all current and past health problems □ None

1. _____ 3. _____
2. _____ 4. _____

List Current Medications (Include inhalers, birth control) (List name, dose, frequency) □ None

1. _____ 3. _____
2. _____ 4. _____

Check if you use any of the following devices □ None

□ Oxygen Flow rate _____ L/min When do you use it?_____
□ CPAP or BiPAP (mask worn when sleeping) Type of CPAP/BiPAP unit_____CPAP pressure_____
Date you started using CPAP_____ Heated humidification?_____
Do you use an oral appliance? _____Yes _____No
If Yes: Type of oral appliance_____ Date you started using oral appliance_____

List All Over-the-counter Medications or Supplements (Vitamins, natural herbs, etc.) □ None

1. _____ 3. _____
2. _____ 4. _____

List any Allergies to Medications (include IV contrast) or Foods and the Reaction □ None

1. _____ 3. _____
2. _____ 4. _____

List All of Your Lifetime Surgeries and Major Injuries □ None

1. _____ 3. _____
2. _____ 4. _____

Social History

Highest education level? □ High School □ Vocational School □ College □ Graduate School

Marital Status? □ Married □ Single □ Divorced □ Widow/Widower □ Co-Habitant

Do you or did you ever smoke? □ Yes □ NoPacks / day_____ How Many Years?_____

Have you ever quit? □ Yes □ No

If yes, for how long did you quit? _____ How did you quit? _____

If yes, when did you quit? _____ How did you quit? _____

Do you use tobacco products other than cigarettes? □ Yes □ No If yes, which ones? _____

Does anyone smoke in your household? □ Yes □ NoHave you ever used illegal substances? □ Yes □ No

Have you ever had trouble with alcohol, drug, or other substance use? □ Yes □ No

Do you have an Advanced Medical Directive / Living Will? □ Yes □ No

Family History (blood related kin)

□ Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? _____

If any of your siblings are deceased, what caused his/her death? _____

Please list any sleep disorders or other significant medical problems in your family:

_____

_____

REVIEW OF SYSTEMS □ CHECK HERE IF YOU HAVE EXPERIENCED NONE OF THE FOLLOWING…

Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below?

CONSTITUTIONAL

□ Unusual fatigue
□ Weight gain. How much? _____ lbs
Over what time frame? _____

ALLERGIC

□ Hay Fever
□ Frequent sneezing
□ Watery eyes
□ Seasonal allergies

CARDIOVASCULAR

□ High blood pressure
□ Abnormally low blood pressure
□ Chest pain on exercise (angina)
□ Irregular beat or palpitation of heart
□ Heart murmur
□ Swelling or edema of ankles
□ History of heart attack
□ History of enlarged heart / heart failure (CHF)

STOMACH AND BOWELS

□ Difficult or painful swallowing
□ Acid Reflux ("Heartburn")
□ Regurgitation
□ Belching
□ Hiatal hernia
□ Stomach ulcer / Intestinal ulcer
□ Nausea or vomiting

EARS, NOSE, THROAT, MOUTH

□ Ear pain / pressure
□ Sinus problems, post nasal drip
□ Nasal congestion, runny nose
□ Hoarseness
□ Frequent need to clear throat

GLANDULAR (LYMPHATIC)

□ Swollen lymph nodes anywhere

LUNGS (RESPIRATORY)

□ Asthma, wheezing
□ Cough for more than 3 weeks
□ COPD / emphysema
□ Ever had collapsed lung?
□ Ever had bullous lung disease?
□ Recurrent bronchitis
□ Shortness of breath

ENDOCRINE

□ Increased thirst, hunger
□ Sensitive to heat/cold
□ Change in skin, body hair
□ Diabetes

PSYCHIATRIC

□ Anxiety
□ Depression
□ Other mood disorder

NEUROLOGIC

□ Unusual dizziness, fainting, or loss of consciousness
□ Ever had a stroke?
□ Ever had a head trauma?
□ Ever had a skull fracture?
□ Seizures

General:

Do you feel that you suffer from insomnia? ..... ___Yes; ___No
Do you feel that you get too little sleep at night? ..... ___Yes; ___No
Do you feel that you get too much sleep at night? ..... ___Yes; ___No

Sleep Hygiene:

What time do you:
-go to bed on weekdays? ____ am pm -on weekends? ____ am pm
-wake up on weekdays? ____ am pm -on weekends? ____ am pm
When you go to bed, how long does it usually take you to fall asleep? _____ minutes
On the average, how long are you awake in the morning before you actually get out of bed ? ____ minutes
Do you take naps during the day? ___Yes; ___No. - If yes, at what time: ___ How long ? ___ minutes
Do you routinely exercise each day? ___Yes; ___No - If yes, at what time: ___
On the average, how many ounces of alcoholic beverages do you consume:-per day? ___ per week? ____
On the average, how many ounces of caffeinated beverages do you consume:-per day? ___ per week?____
Do you usually have a drink containing caffeine or alcohol within 2-3 hours of the time you go to bed?
___Yes; ___No
Have you ever worked shift work ? ___Yes; ___No. - If yes, please describe: _____

How much difficulty do you have with:	never	mild	moderate	severe
- waking up during the night ?	____	____	____	____
- getting back to sleep after waking up during the night ?	____	____	____	____
- waking up in the morning ?	____	____	____	____
- getting out of bed after waking up in the morning ?	____	____	____	____
- waking up with headaches ?	____	____	____	____

On the average, how long are you awake during the night ? _____ minutes

Hypersomnolence (Excessive Sleepiness):

Do you wake up feeling tired or wanting more sleep regardless of how much sleep you get? __Yes; ___No
Do you struggle to stay awake during the day? ___Yes; ___No
Do you fall asleep at meetings/lectures? ___Yes; ___No
Have you ever dozed off at a traffic light or toll booth? ___ Yes; ___ No
Have you ever had an accident operating an automobile or other machinery because of sleepiness or fatigue? ___ Yes; ___ No. If yes, please describe: _____
_____

Besides actual traffic accidents have you ever experienced any of the following while driving?
- Unintended lane shifts? ___Yes ___No. If YES, how often? _____
- Unintended road departures? ___Yes ___No. If YES, how often? _____
- Unintended crossing lights at an intersection? ___Yes ___No. If YES, how often? _____

Do you use caffeine or other stimulants to stay alert ? ___Yes; ___No
If you feel that you have excessive daytime sleepiness, please describe a few experiences that you have had that reflect severe sleepiness.
_____
_____

Sleep Behavior: If you answer yes to the following question, please describe in the space provided.
Do your legs or arms bother you when resting or falling asleep? ___Yes; ___No
_____
_____

Do you have any unusual movements (leg jerks, head movements, etc.) during sleep?___Yes; ___No.

_____

_____

Do you have any unusual sleep behavior (sleep walking, sleep talking, etc.)? ___Yes; ___No.

_____

_____

Do you experience dreams? ___Yes; ___No
Have you noticed a change in your dreams? (i.e. increased, decreased, etc)? ___Yes; ___No
Do you experience nightmares? ___Yes; ___No If yes, please describe:

_____

_____

Breathing Disorders:

Do you experience any breathing problems during sleep ? ___Yes; ___No. If yes, please describe:

_____

_____

Do you or have you been told that:	**Yes**	**No**
-you snore?	____	____
-have pauses in breathing during sleep?	____	____
-difficulty breathing in a flat position?	____	____
-waking up short of breath?	____	____
-waking up choking or gasping for air?	____	____

Narcolepsy:

Have you ever been diagnosed as having narcolepsy? ____Yes; ____No
Has anyone in your family been diagnosed with narcolepsy? ____Yes; ____No

How much difficulty do you have with:

	never	mild	moderate	severe
- feeling sleepy, fatigued, or weak after an emotional experience?	____	____	____	____
- not being able to move when first waking up?	____	____	____	____
- hallucinations when falling asleep or waking up?	____	____	____	____
- sleep attacks (falling asleep despite not wanting to)?	____	____	____	____

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. Please use the following scale:

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. 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 the traffic _____

TOTAL _____

Thank you for your cooperation.

FOR PHYSICIAN (only) "I have personally reviewed and confirmed the above information."

Signature _____ Date _____