Center for Sleep Disorders

A Division of Neurologic Associates, PLC

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Please complete questionnaire and bring it with you the evening of your appointment.

Patient Name: _____

Age: _____ DOB: _____ Height: _____Weight: _____

Patient Questionnaire	YES	NO	Additional Information
Do you go to bed at a regular time every night?	Y	N	If yes, what time?
Do you wake up at a regular time every day?	Y	N	If yes, what time?
Do you have difficulty falling / or staying asleep?	Y	N	
Do you have difficulty sleeping away from home?	Y	N	
While in bed do you read or watch TV?	Y	N	
Do you take naps?	Y	N	If yes, how often and how long?
Has anyone ever observed you having pauses in your breathing at night?	Y	N	If yes, how often?
Do you have excessive daytime sleepiness?	Y	N	
Do you grind your teeth while sleeping?	Y	N	
Do you have leg jerks while sleeping?	Y	N	
Do you have morning headaches?	Y	N	
Do you have shortness of breath at night?	Y	N	
Do you have night sweats?	Y	N	
Do you wet the bed?	Y	N	
Do you have difficulty driving due to your sleepiness?	Y	N	
Have you ever fallen asleep while driving?	Y	N	
Have you gained weight / lost weight over the past year?	Y	N	If so, how much weight was gained/lost in pounds?
Do you ever have sudden unexplained, involuntary or inappropriate sleep attacks?	Y	N	
If yes to the previous question, do you dream during these attacks?	Y	N	
Do you have severe muscular weakness elicited by strong emotions? (i.e. laughing)?	Y	N	
Do you have hallucinations while falling asleep or upon awakening?	Y	N	
Do you have total body paralysis while falling asleep or upon awakening	Y	N	
Do you have a pacemaker?	Y	N	
Have you ever had any cardiovascular problems?	Y	N	
Have you ever had an abnormal EKG?	Y	N	
Has anyone observed you snoring?	Y	N	
If yes to the previous question, do you snore every night?	Y	N	
Has your bed partner ever been forced into another room because of your snoring?	Y	N	

On a scale of 1-10 (**10** being the loudest) how loud do you snore?
How long does it normally take for you to fall asleep after bedtime?
Do you experience any pain while sleeping? If so, please explain the pain:
Do you use caffeine? If so, **What/How much/How often/What time of day?**
Do you smoke and/or drink alcohol? If so, **What/How much/How often/What time of day?**

Have you had any of the following: (Circle all that apply)

Surgery to remove the uvula(UPPP) Deviated Septum Broken Nose

Tonsils Removed Adenoids Removed

Any other nasal or throat surgery? If yes, please explain what type of surgery and when:

_____

Do you have any of the following? (Circle all that apply)

Chronic Pulmonary Disease High Blood Pressure Diabetes Asthma

Have you had a previous sleep study? If so, when and where? What were the results of the study?

_____

Are you currently using CPAP/BiPAP/other? If so, what is your pressure setting?

_____

Do you have any allergies to medications, latex and or/ tape? If yes, please specify:

_____

Epworth Sleepiness Scale: Use the following scale to choose the most appropriate number for each situation

Scale:
0 = **would never** doze
1 = **slight chance** of dozing
2 =**moderate chance** of dozing
3 = **high chance** of dozing

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching television	
Sitting, inactive in a public place (e.g. a theatre or meeting	
As a passaenger 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 lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total:	