Banner Health

ADULT SLEEP QUESTIONNAIRE

PLEASE FILL OUT AND BRING TO YOUR SLEEP STUDY

NAME: _____ AGE/SEX: _____ DATE OF BIRTH: _____
BMI: _____ NECK CIRCUMFERENCE: _____ WEIGHT: _____
HEIGHT: _____ REFERRING PHYSICIAN: _____

What was the reason your physician referred you to have a sleep study performed? _____

SLEEP HABITS

CHECK the box for each problem you CURRENTLY HAVE

	Loud snoring		Nightmares
	Frequent awakenings at night		Morning headaches
	Choking for breath at night		Morning dry mouth
	Gasping during sleep		Sleepwalking
	Witnessed Apnea		Sleep terrors
	(I've been told that I stop breathing when asleep) Restless sleep		Tongue biting in sleep
	Awaken un-refreshed		Bedwetting
	Crawling feelings in legs when trying to sleep		Acting out dreams
	Leg-kicking during sleep		Feeling paralyzed when falling asleep or waking up
	Leg cramps in sleep		Dreamlike images when falling asleep or waking up
	Trouble falling asleep or staying asleep at night		Sudden weakness when laughing
	Racing thoughts when trying to sleep		Sudden weakness when afraid
	Increased muscle tension when trying to sleep		Uncontrollable daytime sleep attacks
	Fear of being unable to sleep		Falling asleep unexpectedly
	Inability to fall back asleep after awakening at night		Falling asleep at work or school
	Laying in bed worrying when trying to sleep		Falling asleep while driving
	Waking too early in the morning		Recent change in sleep schedule
	Sleep talking		Shift work interfering with sleep
	Sweating a lot at night		I use sleeping pills to help me sleep
	Waking up with heartburn or reflux		I use alcohol to help me sleep
	Waking up to urinate		Pain interfering with sleep; where is the pain?
	Teeth grinding during sleep		

DAYTIME SYMPTOMS & COMPLAINTS

Do you nap? ❑ Yes ❑ No
If yes: How often do you nap? _____ times per week

How long are your naps? _____ minutes
Do you feel rested and refreshed? ❑ Yes ❑ No

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SLEEP HISTORY

Please provide the following information:

Your bedtime on WEEKDAYS _____ AM / PM
Time you get up on WEEKDAYS _____ AM / PM
Your bedtime on WEEKENDS _____ AM / PM
Time you get up on WEEKENDS _____ AM / PM
Have you ever had a sleep study before? ❑ Yes ❑ No
If yes: Please indicate where and when you had the study.

_____

_____

Are you a shift worker? ❑ Yes ❑ No
If yes: What kind of shift do you work? _____
Do you currently use a CPAP or BiPAP machine at home? ❑ Yes ❑ No
What are your current pressure settings? _____ cm H2O
Are you on home oxygen? ❑ Yes ❑ No
What liter flow of oxygen? _____ liters per minute.
How long have you been on home oxygen? _____
Do you use the oxygen for sleep only? ❑ Yes ❑ No

Please provide the name of your Home Health Company (DME)

_____

_____

Please rate how likely you would be to actually *doze* off during each situation. Score your rating by circling a number from 0 to 3 points which best describes each situation and total your answers. Even if you have not done some of these things recently, try to recall how they would likely affect you.

0 points = Would never fall asleep
1 point = Slight chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High chance of falling asleep

	SITUATION				
A.	Sitting and reading	0	1	2	3
B	Watching TV	0	1	2	3
C.	Sitting, inactive in a public place (e.g., theater or meeting)	0	1	2	3
D.	As a passenger in a car for an hour without a break	0	1	2	3
E.	Lying down to rest in the afternoon when circumstances permit	0	1	2	3
F.	Sitting down and talking to someone	0	1	2	3
G.	Sitting quietly after a lunch	0	1	2	3
H.	In a car, while stopped for a few minutes in traffic	0	1	2	3
	Totals				
			TOTAL		

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MEDICAL HISTORY

Check if you have now or have had in the past any of the following:

Condition	Current	Previous	Condition	Current	Previous
Diabetes			Anemia		
High Blood Pressure			Peptic Ulcers		
Stroke			Acid Reflux (Heartburn)		
Heart Disease or CHF			Kidney Disease		
Heart Attack			Thyroid Disease		
Angina			Arthritis		
Emphysema or COPD			Back Pain		
Asthma			Head Trauma		
Tuberculosis			Severe Headaches		
Other Lung Disease			Epilepsy (Seizures)		
Nasal Allergies			Passing Out Spells (Fainting)		
Runny or Blocked Nose			Depression		
Hormonal Problem			Anxiety Disorder		
Urological Problem			Problems With Alcohol		
Prostate Problem			Problems With Drugs		

Please list hospitalizations. Please give the reasons for each hospitalization and the dates (as best you can remember).

Reason for Hospitalization	Date

MEDICATIONS

Please list any medications you have taken in the last 6 months. Including vitamins or herbal supplements.

Name	Dose	Frequency	How long taken?	Reason for taking?	Still taking? Yes	No

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ALLERGIES

❑ No known allergies

List any allergies and intolerances to **medications, food or the environment.**

Allergy:	Reaction:

SOCIAL HISTORY

Please list your current average for each category below:

_____ Number of cigarettes smoked per day

_____ Other tobacco products used per day (pipe or cigars)

Have you ever smoked? ❑ Yes ❑ No

When: _____

If you smoke or have ever smoked:

What is the most you have ever smoked? _____

If you have quit, when did you quit? _____

_____ Cups of regular coffee per day

_____ Glasses of cola or other beverages containing caffeine per day

_____ Cans of beer per day (12 oz)

_____ Glasses of wine per day (3-4 oz)

_____ Alcoholic drinks per day (1-2 oz straight or mixed)

If you drink alcohol:

Do you need an eye opener in the morning? ❑ Yes ❑ No

Have you felt the need to quit? ❑ Yes ❑ No

What is your current relationship status?

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Living with someone

What is your occupation? _____

FAMILY HISTORY

Do you have a family history of any major disease? ❑ Yes ❑ No

If yes please describe: _____

_____

Do you have any family history of sleep disorders? ❑ Yes ❑ No

If yes please describe: _____

_____

_____ The information provided above is accurate to the best of my knowledge.

Initials

_____ Would you be willing to participate in a Clinical Research Study?

Initials

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