SLEEP LAB
Patient Questionnaire

Patient Name: _____ Date of Study_____
Age / Date of Birth _____ Marital Status_____ Male _____ Female _____
EMAIL _____
Current--Past Occupation _____
Current Employer: _____ Phone #: _____

Do or did you work shift work? Yes No

Ordering Physician_____.

In the event of an emergency, please list who we should contact:
Name: _____
Phone: _____

Height in inches _____ Weight lbs_____
Neck Circumference _____ inches

1. What time do you usually go to bed on weekdays? Awaken on weekdays?		
2: What time do you usually go to bed on weekends? Awaken on weekends?		
3. How long does it usually take you to fall asleep after you go to bed?		
4. How many hours of sleep do you usually get per night?		
5. How many times are you aware that you awaken during the night?		
6. Please describe your chief sleep/wake complaint (what is the reason for the study)		
a) Do you feel sleep during the daytime?	Yes	No
b) Do you occasionally nap during the day?	Yes	No
c) Do you snore?	Yes	No
d) Does your snoring ever wake you up?	Yes	No
e) Has anyone ever told you that you stop breathing in your sleep?	Yes	No
f) Do you have trouble falling asleep?	Yes	No
g) Do you have trouble staying asleep?	Yes	No
h) Do you feel refreshed when you wake in the morning?	Yes	No
i) Has anyone ever said that your arms or legs jerk while you are sleeping?	Yes	No
j) Do you still have your tonsils?	Yes	No
k) Do you have (or have you had) nasal polyps or growths in your nose or mouth?	Yes	No
l) Do you routinely wake up with morning headaches or generalized aching?	Yes	No
m) Do you perspire at normal temperature while you sleep?	Yes	No
n) Do you ever feel sleepy when driving your car?	Yes	No
o) Have you ever fallen asleep when driving your car?	Yes	No
p) Do you sometimes wake up feeling as though you are choking/gasping for air?	Yes	No
q) Are you a restless sleeper?	Yes	No
r) Do you grind your teeth in your sleep?	Yes	No
7. Do you have any allergies? If yes, please list them.	Yes	No
8. Do you use tobacco? If yes, what form (snuff, cigarettes, pipe, etc)	Yes	No
9. How much? (pack per day) If you used tobacco in the past, how many years did you use and How long ago did you quit?		
10. On average, how many cups of alcohol do you consume daily?		
11. On average, how many cups of caffeinated beverages do you drink daily?		
12. Have you had any significant weight changes lately? gain in lbs loss in lbs	Yes	No
13. What position(s) do you sleep best in (back, sides or stomach)?		

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14. How long do you feel as though you've had a sleep problem?	
15. Do you have problems with memory or concentration?	Yes No
16. Do you walk or talk in your sleep?	Yes No
17. Do you have frightening dreams or nightmares?	Yes No
18. Do you have arthritis, joint or back pain or been diagnosed with Fibromyalgia?	Yes No
19. Have you ever had a heart attack?	Yes No
20. Do you have a history of diabetes?	Yes No
21. Do you have a history of COPD?	Yes No
22. Do you have any other medical conditions that we should be aware of?	Yes No
23. Have you ever had a sleep study in the past?	Yes No
If yes, when? Where? Results?	Yes No
24. Are you currently on any treatment for a sleep disorder?	Yes No
25. Are you currently on Oxygen therapy? If yes, how many liters per minute?	Yes No
26. Have you ever had a spinal cord or serious head injury?	Yes No
27. Do you have nasal stuffiness? If yes, for how long?	Yes No

Medication History - Please be sure to include any prescription, over the counter or herbal medication:

Name of Medication	Times per Day	Reason	Physician

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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 classify how these-situations would affect you by choosing the appropriate number. Use the following scale to choose the ***most appropriate number*** for each situation.

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

Score	**Situation**
	Sitting and reading
	Watching television
	Sitting inactive in a public place (theater, work, park bench)
	As a passenger in a car for an hour without a break
	Lying down in the afternoon when circumstances allow
	Sitting and talking to someone
	Sitting quietly after a lunch without alcohol
	In a car, while stopped for a few minutes for traffic
	Total Score

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We would like to objectively understand to what extent your sleep apnea and snoring is having impact on your daily activities, emotions, social interactions, and about symptoms that may have resulted. Measuring that prior to starting any treatment, and then again at various stages after starting treatment, is very important.

Please use the following scale to choose the ***most appropriate*** number for each situation.

1 = a very large amount
2 = a large amount
3 = a moderate to large amount
4 = a moderate amount
5 = a small to moderate amount
6 = a small amount
7 = not at all

SITUATIONS	SCORE
1. How much have you had to push yourself to remain alert during a typical day?(e.g. work, school, childcare, housework)	
2. How often have you had to use all your energy to accomplish your most important activity? (e.g. work, school, childcare, housework)	
3. How much difficulty have you had finding the energy to do other activities? (e.g. exercise, relaxing activities)	
4. How much difficulty have you had fighting to stay awake?	
5. How much of a problem has it been to be told that your snoring is irritating?	
6. How much of a problem have frequent conflicts or arguments been?	
7. How often have you looked for excuses for being tired?	
8. How often have you not wanted to do things with your family and/or friends?	
9. How often have you felt depressed, down, or hopeless?	
10. How often have you been impatient?	
11. How much of a problem has it been to cope with everyday issues?	
12. How much of a problem have you had with decreased energy?	
13. How much of a problem have you had with fatigue?	
14. How much of a problem have you had waking up feeling unrefreshed?	
Total score	

PRINTED PATIENT NAME: _____ DATE: _____

DOB: _____