CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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PATIENT SLEEP QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint: *(check all that apply)*

☐ Trouble sleeping at night
For how many months/years? ____

☐ Being sleepy all day
For how many months/years? ____

☐ Snoring
For how many months/years? ____

☐ Unwanted behaviors during sleep Explain: _____

☐ Other Explain: _____

Sleep Pattern

	Work Days (*Weekday*)	Off Days (*Weekends*)		Work Days (*Weekday*)	Off Days (*Weekends*)
Typical bedtime			Typical amount of time to back asleep after an awakening		
Typical amount of time it takes to fall asleep			Typical wake up time		
Typical number of awakenings per night			Desired wake up time		
List any activities that you normally do during nighttime awakening(s) *(i.e. restroom, eat, watch TV)*			How do you usually awaken (*i.e. alarm clock*)		
			Typical time you get out of bed		
			Total amount of sleep per night		
			Number of naps per day		

Please check all of the following statements that are true about your sleep:

Sleep Habits

☐ I usually watch TV or read in bed prior to sleep
☐ I frequently travel across 2 or more time zones
☐ I drink alcohol prior to bedtime
☐ I smoke prior to bedtime or when I awaken during the night
☐ I eat a snack at bedtime
☐ I eat if I awaken during the night
☐ I typically awaken to urinate during sleep
☐ I have trouble falling asleep
☐ I awaken frequently during the night
☐ I am unable to return to sleep easily if I awaken during the night
☐ Thoughts start racing through my mind when I try falling asleep
☐ I awaken early in the morning, still tired but unable to return to sleep
☐ I have nightmares as an adult
☐ I experience a creeping-crawling or tingling in my legs when I try to fall asleep
☐ I sweat a great deal during sleep
☐ I cannot sleep on my back

Breathing

- ☐ I have been told that I stop breathing while asleep
- ☐ I awaken at night choking, smothering or gasping for air
- ☐ I have been told that I snore
- ☐ I have been told I snore only when sleeping on my back
- ☐ I have been awakened by my own snoring

Restlessness

- ☐ I am a restless sleeper
- ☐ I kick or jerk my legs and/or arms during sleep
- ☐ I experience a restlessness, tingling or crawling in my arms or legs
- ☐ I experience an inability to keep my legs still prior to falling asleep
- ☐ I talk in my sleep as an adult
- ☐ I have sleep walked as an adult
- ☐ I grind my teeth in my sleep

Daytime Sleepiness

- ☐ I take daytime naps
- ☐ I have a tendency to fall asleep during the day
- ☐ I have experienced lapses in time or blackouts
- ☐ I have fallen asleep while driving
- ☐ I have had auto accidents as a result of falling asleep while driving
- ☐ I fall asleep during conversations
- ☐ I fall asleep in sedentary situations
- ☐ I performed poorly in school because of sleepiness
- ☐ I have had injuries as the result of sleepiness
- ☐ I have experienced sudden muscle weakness in response to emotions such as laughter, anger or surprise
- ☐ I have experienced an inability to move while falling asleep or waking up
- ☐ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up
- ☐ I drink caffeinated beverages during the day

  _____ cups/bottles/cans per day

MEDICAL HISTORY

Vital Statistics

What is your: Height: _____ Weight: _____ Neck Size: _____

What was your weight one year ago? _____ Five years ago? _____

Past Sleep Evaluation and Treatment

- ☐ I have had a previous sleep disorder evaluation
- ☐ I have had previous overnight sleep studies
- ☐ I have had daytime nap studies
- ☐ I have been prescribed a CPAP or bi-level machine for home use
- ☐ I have had surgical treatment for a sleep disorder
- ☐ I have previously been prescribed medication for a sleep disorder
- ☐ I have been previously treated for a sleep disorder

Past Medical History

- ☐ Hypertension (*High Blood Pressure*)
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stomach or Colon problems
- ☐ Lung problems/COPD/Asthma
- ☐ Reflux
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ TIA *"Light Stroke"*
- ☐ Blackouts
- ☐ Seizures
- ☐ Back or Joint problems (*Arthritis)*
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Hepatitis/Jaundice
- ☐ Hearing impairment
- ☐ Depression or Severe Anxiety
- ☐ Alcoholism
- ☐ Chemical dependency or abuse

Female

- ☐ Premenstrual Syndrome
- ☐ Menopause

Male

- ☐ Prostate problems
- ☐ Erectile Dysfunction/Impotence

List other past medical problems and dates:

_____ _____

_____ _____

_____ _____

List surgeries and the year:

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications:

Medication	Dose	# Times Per Day		Medication	Dose	# Times Per Day

Allergies: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Sleep alone
☐ Share a bed with someone
☐ Share a bedroom, but have separate beds
☐ Share a dwelling, but have separate bedrooms

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

☐ My job requires driving a vehicle
☐ I work with dangerous equipment or substances
☐ I am a shift worker on rotating shifts
☐ I am a permanent or long term third shift worker
☐ I am currently a student

Habits:

Do you smoke? ☐ Yes ☐ No

If Yes: What	Amount Per Day	For How Many Years
☐ Cigarettes	_____ pack(s)	_____
☐ Cigars	_____ cigars	_____
☐ Tobacco	_____ pipes	_____

Do you drink alcohol? ☐ Yes ☐ No

If Yes: What	Frequency	Amount Per Week
☐ Beer	☐ Daily ☐ Weekends ☐ Rare	_____ cans
☐ Wine	☐ Daily ☐ Weekends ☐ Rare	_____ glasses
☐ Liquor	☐ Daily ☐ Weekends ☐ Rare	_____ shots

Family History:

Has an immediate blood relative had any of the following?

Yes	No	Thyroid Disease	Relation
☐	☐	Cancer	_____
☐	☐	Diabetes	_____
☐	☐	Hypertension	_____
☐	☐	Heart Disease	_____
☐	☐	Thyroid Disease	_____

Yes	No		Relation
☐	☐	Stroke	_____
☐	☐	Anxiety/Depression	_____
☐	☐	Sleep Apnea	_____
☐	☐	Narcolepsy	_____
☐	☐	Other: _____	_____

Review of Systems

In the PAST 12 MONTHS, check any of the following symptoms you have had:

Yes	No		Yes	No	
☐	☐	Frequent headaches	☐	☐	Frequent heartburn or indigestion
☐	☐	Fainting or passing out	☐	☐	Abdominal pain
☐	☐	Sudden loss of vision or strength, or inability to speak	☐	☐	Frequent constipation
☐	☐	Hearing loss or ringing in ear(s)	☐	☐	Frequent diarrhea
☐	☐	Hoarseness for more than 2-4 weeks	☐	☐	Rectal bleeding / black stools
☐	☐	Nosebleeds	☐	☐	Difficulty urinating / incontinence
☐	☐	Cough for more than 2-4 weeks	☐	☐	Blood in urine
☐	☐	Coughing up blood	☐	☐	Urinating more than 2 times per night

Review of Systems (continued)

In the PAST 12 MONTHS, check any of the following symptoms you have had:

Yes	No		Yes	No	
☐	☐	Shortness of breath or wheezing	☐	☐	Pain in joints or bones
☐	☐	Swelling in feet or ankles	☐	☐	Unusual bleeding or bruising
☐	☐	Chest pain, chest pressure or heaviness	☐	☐	Convulsions
☐	☐	Irregular heartbeat or sudden fast heartbeat	☐	☐	Change in wart, mole or skin growth
☐	☐	Difficulty swallowing or food “sticking”	☐	☐	Weight loss of more than 5-10 lbs.

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. 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

4 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or 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:	**0**

Notes

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Please have your bed partner complete this form.

Check any of the following behaviors that you have observed the patient doing while asleep.

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Twitching of legs or feet during sleep
- ☐ Pause in breathing
- ☐ Grinding teeth
- ☐ Sleep talking
- ☐ Sleepwalking
- ☐ Bed wetting
- ☐ Sitting up in bed but not awake
- ☐ Head rocking or banging
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud “snorts”?

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