CTNG 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*)
Typical bedtime		
Typical amount of time it takes to fall asleep		
Typical number of awakenings per night		
List any activities that you normally do during nighttime awakening(s) *(i.e. restroom, eat, watch TV)*		

	Work Days (*Weekday*)	Off Days (*Weekends*)
Typical amount of time to back asleep after an awakening		
Typical wake up time		
Desired wake up time		
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	
☐	☐	Frequent headaches
☐	☐	Fainting or passing out
☐	☐	Sudden loss of vision or strength, or inability to speak
☐	☐	Hearing loss or ringing in ear(s)
☐	☐	Hoarseness for more than 2-4 weeks
☐	☐	Nosebleeds
☐	☐	Cough for more than 2-4 weeks
☐	☐	Coughing up blood

Yes	No	
☐	☐	Frequent heartburn or indigestion
☐	☐	Abdominal pain
☐	☐	Frequent constipation
☐	☐	Frequent diarrhea
☐	☐	Rectal bleeding / black stools
☐	☐	Difficulty urinating / incontinence
☐	☐	Blood in urine
☐	☐	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:	________

Notes

Terry S. Peery, D.O.

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