

Patient Sleep Wake QUESTIONNAIRE

This questionnaire is for patients 13 years of age or older that have a **scheduled appointment** at the Sleep Center. It will take approximately 15 to 20 minutes to complete. The information you provide is **very** important and will assist the sleep specialist during the review of your sleep symptoms. This questionnaire has been compiled based on many years of accumulated experience in Sleep Medicine. The information will be treated with the utmost discretion and will not be used by any party other than Palo Alto Medical Foundation (PAMF). Please respond to all questions by checking the appropriate box or completing the free text sections. If you have a bed partner, a parent or guardian, or otherwise someone who is willing to and is able to comment on your sleep patterns or behaviors during sleep please have them complete Section 11.

 Patient name:

 Scheduled Appointment Date:

 Sleep Specialist:

 Today's Date:

 DOB:

 Age:

 Sex:

 Height (inches):

 Weight now (lbs):

 Weight 1 year ago:

 Weight 5 years ago:

 Marital Status:

 Number of Children:

 I was referred by:

 Name of Doctor:

Specific issues I want to discuss at my appointment (please, list in order of concern):

1.

2.

3.

1. SLEEP SCHEDULE

What time do you go to bed on **weekdays**? _____ a.m. p.m.

What time do you go to bed on **weekends**? _____ a.m. p.m.

What time do you get out of bed on **weekdays**? _____ a.m. p.m.

What time do you get out of bed on **weekends**? _____ a.m. p.m.

How much sleep do you get on an average night (hours)? _____

Are you a morning type, evening type, neither... _____

What would be your ideal bedtimes? (**from** (a.m./p.m.) **to** (a.m./p.m.)) _____

Do you nap? Yes No

How often do you nap? (number of times per week) _____

How long are the naps? (in minutes) _____

Do you awaken refreshed from the nap? Yes No

What are your usual work hours? _____

Are you a shift worker? Yes No

If yes, what kind of shift do you work (hours)? _____

What is (was) your occupation? _____

If retired, when? _____

2. SLEEP HISTORY

Do you have difficulty falling asleep? Yes No

Do you have difficulty staying asleep? Yes No

Do you wake up too early and cannot get back to sleep? Yes No

Do you have thoughts racing through your mind that make it difficult to sleep? Yes No

How long does it take you to fall asleep at night (minutes)? _____

Do you read in bed? Yes No

- Do you watch TV in bed? Yes No
- Do you share the bed with anyone? Yes No
- Does your partner have a sleep disorder? Yes No
- Do you have pets sleep in the bedroom? Yes No
- Is your bedroom comfortable? Yes No

If **yes**, please describe:

How many times do you wake up during the night? _____

How long does it take you to fall asleep again (minutes)? _____

- Do you have unpleasant feelings of fear, anxiety, tension, or unhappiness waking you up? Yes No
- Do you have feelings of muscle tension or tightness in your arms or chest? Yes No
- Do you have pain or joint discomfort? Yes No
- Do you have other problems waking you up? Yes No

If **yes**, please describe:

In the morning, do you wake up with an alarm, naturally, both: _____

In the morning, do you wake up feeling sleepy, groggy, refreshed, tired: _____

3. ABNORMAL MOVEMENTS/BEHAVIORS

Do you have or have you ever experienced:

- An urge to move your legs, usually accompanied by uncomfortable and unpleasant sensations in the legs? Yes No
- Discomfort in the legs that worsen during periods of rest or inactivity such as laying down or sitting? Yes No
- Discomfort in the legs that is relieved by movement: walking or stretching? Yes No
- Discomfort that worsens during the nighttime? Yes No

Do you have leg cramps (Charley horse)? Yes No

Do you kick or jerk your arms or legs during sleep? Yes No

Are your bed covers messy in the morning? Yes No

Do you kick, punch, or poke your bed partner while asleep? Yes No

If yes, have you ever injured your bed partner or yourself? Yes No

Do you grind your teeth? Yes No

Do you wear a bite splint (mouth guard)? Yes No

Do you walk in your sleep? Yes No

If yes, when was the last time?

Do you talk in your sleep? Yes No

Do you have nightmares or night terrors? Yes No

If **yes**, please describe the behavior, including the time of night, and frequency:

Have you acted out your dreams? Yes No

Do you make rolling movements or bang and twist your head at night? Yes No

Have you had sleep problems as a child? Yes No

If **yes**, please describe:

4. DAYTIME SLEEPINESS

Have you fallen asleep unexpectedly? Yes No

Have you ever had an accident or near-miss because you have fallen asleep while driving? Yes No

If **yes**, when?

Have you **ever** experienced sudden muscle weakness when you laugh, listen to a joke, are surprised or angry? Yes No

If **yes, during** your episode of muscle weakness. If **no**, please skip to the next question

a) Can you hear? Yes No

b) Does your speech ever become slurred? Yes No

c) Is your head affected? Yes No

d) Is your whole body affected? Yes No

e) How long does the weakness usually last?

Have you experienced dreamlike images or sounds while falling asleep or waking up? Yes No

Have you experienced an inability to move while falling asleep or waking up? Yes No

THE EPWORTH SLEEPINESS SCALE

How likely are 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

3 = high chance of dozing

Sitting and reading

Watching TV

Sitting, inactive in a public place (e.g. a theatre 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 score out of 24:

5. SNORING/BREATHING HISTORY

Do you snore?

What is your preferred sleep position (% of the time in each)?

Back (% of sleep time)

Left Side (% of sleep time)

Right Side (% of sleep time)

Stomach (% of sleep time)

Does your sleep position affect your snoring?

Yes No

Do you awaken with a snort, choking or gasping for air?

Yes No

Do you awaken with a headache?

Yes No

Has anyone noticed you stop breathing while asleep?

Yes No

Do you awaken often to urinate during the night?

Yes No

Do you awaken with acid or sour taste in your mouth?

Yes No

Do you have difficulty breathing while on your back?

Yes No

Do you avoid sharing a room because of snoring?

Yes No

Do you sweat excessively during the night?

Yes No

Do you awaken with a dry mouth or sore throat?

Yes No

6. MEDICAL/SURGICAL HISTORY

Have you ever had a sleep study in the past?

Yes No

If **yes**, when?

If **yes**, where?

Do you use CPAP or BiPAP at home?

Yes No

If yes, what pressure setting?

Do you use oxygen at home?

Yes No

If **yes**, what Liter/flow setting?

Have you ever had tonsils or adenoids removed?

Yes No

Have you ever had sinus or nasal surgery?

Yes No

Have you ever broken your nose?

Yes No

Have you ever had any type of head injury?

Yes No

Have you ever had surgery to promote weight loss?

Yes No

If **yes**, when?

Have you had dental surgery or orthodontics?

Yes No

If **yes**, please describe:

Please check the appropriate box if you have a history of any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Cardiac arrhythmias | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Lung Problems/COPD/Asthma | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Anemia/Iron deficiency | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexual dysfunction/loss of libido | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Seizures | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Frequent blood donations | <input type="checkbox"/> Connective tissue disease (e.g. Lupus) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Nasal allergies/congestion | <input type="checkbox"/> End stage kidney disease/dialysis | <input type="checkbox"/> Other |

If **other**, please specify:

7. FAMILY HISTORY

Does any member of your family have any of the following?

Snoring or Sleep apnea?

Yes No

If **yes**, relationship

Narcolepsy?

Yes No

If **yes**, relationship

Seizure disorder?

Yes No

If **yes**, relationship

Depression?

Yes No

If **yes**, relationship

Hypertension, heart disease, heart failure?

Yes No

If **yes**, relationship

Stroke?

Yes No

If **yes**, relationship

Diabetes?

Yes No

If **yes**, relationship

8. ALLERGIES

Please list any known medication or environmental (pets, pollens, food, etc.) allergies

9. MEDICATIONS

List current medications (name, dose, and number taken per day), includ OTC and vitamin/herbal supplements..

10. SOCIAL HISTORY

Do you use tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipe)?

If **yes** Packs per day?

If **yes**, when did you start?

If **yes - quit**, when did you quit?

Do you drink alcohol?

Yes No

If **yes**, how many drinks?

per (day, week)

Do you drink caffeinated beverages?

Yes No

If **yes**, how many cups (8 oz.) per day?

Do you use recreational drugs?

Yes No

Do you exercise?

Yes No

This completes the patient portion of the questionnaire. If you have a bed partner, a parent or guardian, or otherwise someone who is willing to and is able to comment on your sleep patterns or behaviors during sleep please have them complete Section 11. Otherwise please skip to Section 12, Sleepiness and Driving.

11. BED PARTNER, PARENT OBSERVATION QUESTIONNAIRE

Do you live with the patient? Yes No

Do you sleep in the same room as the patient? Yes No

If **no**, is it because of his/her sleep behaviors (i.e. snores too loud acts out dreams, etc)? Yes No

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Light snoring | <input type="checkbox"/> Pauses in breathing |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Twitching of legs or feet during sleep | <input type="checkbox"/> Sleep-talking |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Head rocking or banging | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Sitting up in bed but not awake | <input type="checkbox"/> Kicking with legs during sleep | <input type="checkbox"/> Biting tongue |
| <input type="checkbox"/> Getting out of bed but not awake | <input type="checkbox"/> Becoming very rigid and/or shaking | <input type="checkbox"/> Other |

(How long have you been aware if the sleep behavior(s) _____

Describe the behavior(s) 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.

Name of person completing this form: _____

Relationship to patient: _____

12. Driving While Drowsy

Excessive Daytime Sleepiness (EDS) can be caused by many different sleep problems and can result in seriously impaired performance and quality of life. We feel obligated to inform you about EDS because of its potential for increased risk of motor vehicle accidents and injuries due to driving while drowsy.

People with EDS often drive drowsy and are twice as likely to be in a car accident when compared with the general population. The car crash is also likely to be more serious, and the rate of personal injury and death due to car crashes amongst people with EDS is three to five times greater than that of the general population. Drowsiness and driving is a dangerous combination. It can be as dangerous as driving drunk. Like alcohol, drowsiness slows reaction time, decreases awareness, and impairs judgement

Only sleep can truly overcome drowsiness. Caffeine may make you feel more alert, but the results are temporary. Turning up the radio, rolling down the windows, getting out of the car and walking, or slapping yourself are not effective means of waking up. The only true remedy for drowsiness is sleep.

If you find yourself becoming drowsy while driving then you should pull over immediately. Options for getting home safely include taking a nap on the side of the road until you are rested enough to drive, calling a friend or family member to come pick you up, or taking a cab or public transportation home. Drowsy driving accidents most often occur when a driver is alone in the vehicle, so carpooling provides someone who can alert the driver of danger and take over behind the wheel if necessary.

The only safe driver is an alert one. Under no circumstances should you drive while drowsy. By using the **Acknowledge - Submit** button below, you acknowledge that you have been informed of the consequences of driving a motor vehicle while drowsy.

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