CHRISTUS ST. VINCENT Regional Sleep Cent

Sleep Disorders Center 505-820-5363
455 St. Michael's Dr. 505-989-6409 fax
Santa Fe, New Mexico 87505

QUESTIONNAIRE

NAME: _____ **DOB:** _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

Do you now have or have you had:

Hypertension (high blood pressure)	Yes	No
Sinus problems	Yes	No
Allergies	Yes	No
Heart problems	Yes	No
Stroke	Yes	No
Tonsillectomy	Yes	No
Nasal fracture or surgery	Yes	No

PLEASE EXPLAIN ANY YES ANSWERS: _____

_____

_____

_____

OTHER MEDICAL PROBLEMS AND/OR SURGERIES: **DATE:** _____

1. _____

2. _____

3. _____

4. _____

HEIGHT: _____ **WEIGHT:** _____

CURRENT MEDICATIONS: _____

_____ _____

_____ _____

_____ _____

Please answer the following questions on a scale of 0 to 4 (0: not at all; 4: very great)

1. How great a problem do you have with sleepiness (feeling sleepy, struggling to stay awake during the daytime)?	0	1	2	3	4
2. How great a problem do you have with fatigue (tiredness exhaustion, lethargy even when you are not sleepy)?	0	1	2	3	4
3. Do you snore?	0	1	2	3	4
4. Do you hold your breath or stop breathing while asleep?	0	1	2	3	4
5. Do you have gas, indigestion or heartburn at night?	0	1	2	3	4
6. Do you have night sweats?	0	1	2	3	4
7. Do you have frequent headaches in the morning?	0	1	2	3	4
8. Number of times you wake up to urinate?	0	1	2	3	4
9. Do you have difficulty breathing while lying flat?	0	1	2	3	4
10. Do you have shortness of breath with exertion?	0	1	2	3	4
11. Do you choke while eating?	0	1	2	3	4
12. When you awaken from sleep do you ever feel paralyzed, unable to move even though you are awake?	0	1	2	3	4
13. When someone startles you or makes you laugh do you get weak, fall or do your knees buckle?	0	1	2	3	4
14. When falling asleep do you have vivid dreams or hallucinations?	0	1	2	3	4
15. Do you have frequent uncontrollable bouts of sleep or an irresistible urge to sleep?	0	1	2	3	4
16. Do you have problems breathing through your nose?	0	1	2	3	4
17. Are you a mouth breather?	0	1	2	3	4
18. Do you wake up with a dry mouth?	0	1	2	3	4
19. Do you wake up gasping or short of breath?	0	1	2	3	4

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20. Do you have problems with memory or concentration?	0	1	2	3	4
21. Do you have problems with libido or impotence?	0	1	2	3	4
22. Are you irritable?	0	1	2	3	4
23. Do you feel depressed?	0	1	2	3	4
24. Do you feel anxious?	0	1	2	3	4
25. Have you had motor vehicle accidents caused by sleepiness?	0	1	2	3	4
26. Do you fight sleep while driving?	0	1	2	3	4
27. Do you grind your teeth?	0	1	2	3	4
28. Do your ankles swell?	0	1	2	3	4

SLEEP HISTORY:

Usual bedtime _____

Usual length of time to fall asleep _____

Usual wake-up time _____

Average total sleep time _____

Average number of awakenings _____

Average length of awakenings _____

Do you nap during the day? Yes No

If yes, number of naps _____

Length of naps _____

Are naps refreshing? Yes No

Do your legs kick or twitch frequently during the night? Yes No

Do you have symptoms of restless legs (crawling or aching feeling and inability to keep your legs still)? Yes No

Do you feel refreshed or restored in the morning? Yes No

How long does it take you to "get going"? _____

Weekends or days off:

Usual bedtime _____

Usual wake up time _____

Total sleep time _____

Describe your sleep environment:

Watch TV Yes No

Bed partner Yes No

Animals in room Yes No

Room temperature _____

Other _____

_____

SOCIAL HISTORY:

What is your present occupation?_____

What are your work hours?_____

Have you ever smoked? Yes No

If yes, how many years? _____

Average number of packs/day? _____

Have you quit smoking? Yes No

When? _____

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Do you drink alcoholic beverages? Yes No

If yes, what is your consumption? Light Moderate Heavy

Do you drink caffeinated beverages ? Yes No

How many per day?_____

Do you exercise? Yes No

How often per week?_____

Do you have any unusual eating habits? Yes No

Please explain_____

FAMILY HISTORY:

Marital status: single married divorced separated widowed

Children _____ _____ _____
Number ages health problems

Mother living? Yes No Age_____ Medical problems/cause of death:

_____

Father living? Yes No Age_____ Medical problems/cause of death:

_____

Brothers? _____ Health problems_____
Ages

Sisters? _____ Health problems_____
Ages

Do any members of you family have sleep problems: If so, please describe:

_____

_____

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze 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 imagine how they would affect you. Use the following scale to choose the most appropriate number in each situation.

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

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (i.e.: theater, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down for a rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Now that you have finished the questionnaire, do you have any other comments you would like to add?_____

_____

_____

_____

_____