FRONTIER DIAGNOSTIC Sleep Center SLEEP WELL LIVE WELL

8425 South 84th Street
Suite B
Omaha, NE 68127
Phone: 402.339.7378
Fax: 402.339.9455

SLEEP QUESTIONNAIRE

NAME: _____ DATE _____
Last First MI

ADDRESS: _____
Street Address

_____
City State Zip

PHONE: (___) _____ BIRTHDATE: _____ HEIGHT: _____ WEIGHT: _____
Home

(___) _____ AGE: _____ SEX: _____ BED PARTNER ___ NO __ YES
Work

Referring Physician _____

Primary Care Physician _____

INSURANCE CO.: _____

Why are you being seen at Frontier Diagnostic Sleep Center? _____

_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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

	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater or meeting)	_____
As a passenger in a car for an hour (no break)	_____
Lying down in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
TOTAL	_____

Name: _____Date: _____

List the medications that you are presently taking:

MEDICATION	AMOUNT

ALLERGIES:_____

Have you ever had a sleep study previously? _____No _____ YES

If yes, when_____ where _____

If yes do you know the results_____

Please answer all of the questions on this questionnaire. When given a choice, please choose the single best answer. If you have any comments to add, please write them in the space next to the question.

1 = NEVER 2 = OCCASIONALLY 3 = FREQUENTLY 4 = ALMOST ALWAYS

(Circle only one answer)

1. How often do you have any problems with your sleep? 1 2 3 4

2. How many years have you had problems with your sleep? _____

3. How often do you have problems with excessive daytime sleepiness? 1 2 3 4

4. How many years have you had problems with excessive daytime sleepiness? ____

5. How many hours do you usually sleep at night? ___ Less than 4 hours ___ 6-8 hours ___ 4-6 hours ___ 8-10 hours

6. What is your normal bedtime? ___ AM PM

7. What is your normal awakening time? ___ AM PM

8. How often does your bedtime vary from night to night? ___ Rarely ___ Frequently ___ Occasionally ___ Almost Always

9. How often do you sleep on your back? 1 2 3 4

10. How often do you have difficulty going to sleep at night? 1 2 3 4

11. How often do you have trouble staying asleep? 1 2 3 4

12. How many times during sleep do you typically wake up for more than 3-5 minutes? _____

Name: _____Date: _____

1 = NEVER 2 = OCCASIONALLY 3 = FREQUENTLY 4 = ALMOST ALWAYS

13. At the present time, how often do you snore? 1 2 3 4

14. All together, how many years have you snored? ___

15. When you now snore, it is usually....

___ Light or quiet (barely audible in the room)
___ Average (easily heard in the room, but not disruptive)
___ Moderately loud (disturbs my bed partner)
___ Extremely loud (can be heard by people outside of the room)

16. If you snored in the past, was it usually....

___ Light or quiet ___ Moderately loud
___ Average ___ Extremely loud

17. How often do you make loud and disruptive noises (not snoring) when you breathe during sleep? 1 2 3 4

.18. As far as either you or your bed partner know, your breathing during sleep is...

____ Normal or I don't know
____ Sometimes interrupted by long pauses (10 or more seconds of absent or shallow breathing)
____ Frequently interrupted by long pauses
____ Continuously interrupted by long pauses

19. When you get out of bed in the morning, do you feel refreshed and ready to start the day? 1 2 3 4

20. How often do you have a problem throughout the day due to tiredness and fatigue? 1 2 3 4

21. Following a normal night's sleep, do you have difficulty with becoming drowsy when not physically active? (For example: while reading, watching television, or at the movies?) 1 2 3 4

22. Following a normal night's sleep, do you have difficulty with sleepiness when physically active and may even unintentionally fail asleep for short periods? (For example: while in conversation with other people, driving a car, working, during sexual intercourse, etc?) 1 2 3 4

23. Do you have difficulty concentrating and focusing attention during the day? 1 2 3 4

24. If you work, how often do you have difficulty doing your job because of sleepiness? 1 2 3 4

25. How would you rate your overall health? ___ Excellent ___ Fair ___ Good ___ Poor

26. For your age and height, your weight is...

___ Less than it should be
___ 5 - 15% above ideal body weight
___ 15 - 25% above ideal body weight
___ More than 25% above ideal body weight

Name: _____Date: _____

1= NEVER 2 = OCCASIONALLY 3 = FREQUENTLY 4 = ALMOST ALWAYS

27. Have you gained weight recently?
No Yes How much?

28. How often do you awaken from sleep or in the morning with a headache? 1 2 3 4

29. Do you have a small jaw?
_No _Yes __ Slightly smaller than normal
__ Moderately smaller than normal
__Much smaller than normal

30. Do you regularly have a problem breathing through your nose?
__No __Some __Moderate __Severe

31. How often do you awaken with night sweats? 1 2 3 4

32. How often do you awaken and experience heart palpitations or feel your heart racing at night? 1 2 3 4

33. How often do you awaken with choking or the sensation of not breathing? 1 2 3 4

34. How often do you awaken with heartburn? 1 2 3 4

35. How often do you experience stomach acid coming up into your throat or mouth during sleep? 1 2 3 4

36. On average, how many times during the night do you go to the bathroom to urinate?
_____

37. If you are male, have you had problems with impotence? ___No __Yes How long? _____

38. When you sleep, do you disturb your bed partner by persistent twitching or jerking of your arms or legs? 1 2 3 4

39. When falling asleep at the beginning of the night, how often do you experience crawling or aching sensations in your legs and and inability to keep your legs still? 1 2 3 4

40. Compared to the past, your interest in sex is... ___ About the same ___ Much less
___ A little less ___ No interest at all

41. Are you more irritable than in the past? ___ No ___ Quite a bit more
___ A little more ___ A lot more

42. Do you experience depression? ___ No ___ Quite a bit more
___ A little more ___ A lot more

43. Are you overcome with daytime sleepiness, but feel refreshed after a nap? 1 2 3 4

44. Do you experience vivid dream-like images while falling asleep or when awakening from sleep? (Either day naps or sleep at night) 1 2 3 4

Name: _____Date: _____

1 = NEVER 2 = OCCASIONALLY 3 = FREQUENTLY 4 = ALMOST ALWAYS

45. Do you awaken from sleep or a nap with the feeling that you are unable to move or are paralyzed? 1 2 3 4

46. Do you experience sudden muscular weakness or "weak knees" 1 2 3 4 when you laugh, are angry, or in other emotional situations?

47. Do you use alcohol to help you sleep at night? 1 2 3 4

48. How often do you use sleeping medications or tranquilizers to help you sleep at night? 1 2 3 4

49. How often do you drink alcoholic beverages?
__Never __Once a month _1 - 2 times per week _Nearly every day

50. Have you ever smoked cigarettes regularly? …….. ___No ___Yes
How many years altogether have you smoked? _____
Overall, how many cigarettes a day would you typically smoke? _____
Do you smoke now?…… ___No ___Yes
How many do you average per day? _____

Do you do shift work? …… ___No (Go to next Page)

___Yes (answer the Following questions

:

How many days per week do you work? _____

What hours do you work? _____

What is your bed time on the days you work? _____

What is your arousal time on the days you work? _____

What is your bed time on the days you don't work? _____

What is your arousal time on the days you don't work? _____

Does your schedule rotate? ……..... ___No ___Yes

If yes, how often? _____

When sleeping during the day, do you:
_____put signs on the door to warn people not to ring the doorbell?
_____turn off the telephone?
_____darken the bedroom?

What are your sleeping habits the day before you return to your night shift work _____

_____

_____

Name: _____Date: _____

Do you suffer from insomnia? …… ___**No (Go to next Page)**

___**Yes (answer the Following questions)**

How long has insomnia been a problem for you? _____

Do you know what started your insomnia? _____

What is your bed time as a rule? _____

What is your arousal time as a rule? _____

How long do you estimate that it normally
takes you to fall asleep once you go to bed? _____

If you awaken routinely during the night,
how long does it take you to achieve sleep? _____

If you work, does your bed time and arousal time differ from usual
on the weekends or your days off? ..... NO YES

Do you use sleeping pills? ..... NO YES
If yes, which ones? _____

How long? _____

Is your room quiet? ..... NO YES

Is your room dark? ..... NO YES

Is your room comfortable temperature wise? ..... NO YES

Does your bed partner snore at night? ..... NO YES

Does your bed partner legs twitch at night? ..... NO YES

Does your insomnia interfere with your routine performance the
following day? ..... NO YES

Do you nap? ..... NO YES
If yes, how often? _____How long? _____

If you wake up repeatedly at night, are you aware of what awakens you? ..... NO YES

What is your pattern if you have not achieved sleep in 30 minutes?
___Out of bed until tired? ___ Stay in bed?

If you have insomnia and do not achieve sleep until several hours after bedtime, would you sleep late if possible or get up at your usual time?
___Sleep late ___Up at usual time

Do you drink caffeine? ..... NO YES
If, yes, how much? _____
What kinds? _____
What time of day? _____

MEDICAL HISTORY:

Have you ever been diagnosed or treated by a physician for any of the following:

			If yes, when?
Hypertension (high blood pressure)	NO	YES	
Cardiac Arrhythmia (heart irregularities)	NO	YES	
Coronary Heart Disease (hardening of the arteries)	NO	YES	
Angina (heart pain)	NO	YES	
Myocardial Infarction (heart attack)	NO	YES	
Congestive Heart Failure	NO	YES	
Pulmonary Hypertension	NO	YES	
Polycythemia (excessive red blood cells	NO	YES	
Edema (water retention)	NO	YES	
Hiatal Hernia	NO	YES	
Gastric Reflux	NO	YES	
Hypothyroidism (low thyroid)	NO	YES	
Nasal Polyps	NO	YES	
Hayfever or Allergic Rhinitis	NO	YES	
Deviated Nasal Septum	NO	YES	
Vocal Cord Disease (for example: polyps)	NO	YES	
Chronic Lung Disease (any kind)	NO	YES	
Asthma	NO	YES	
Bronchitis	NO	YES	
Emphysema	NO	YES	
Neuromuscular Disease	NO	YES	
Diabetes	NO	YES	
Fibromyalgia	NO	YES	
Kidney Dialysis	NO	YES	
Depression	NO	YES	

Please list all surgeries/operations you have had. _____

_____

_____

Family History:

Is there any family history of sleep apnea, narcolepsy, or other sleep problems? _No ____ Yes If yes please describe

_____

If your parents are still alive, describe their age and health and if not, what caused their death.

_____

_____

Is there anything else in your family history that you want us to know_____

_____

_____

Signature: _____ Date: _____