Sleep Medicine of DFW

ADULT SLEEP QUESTIONNAIRE

PLEASE FILL OUT AND EMAIL IT TO: SleepMedicine@dfwmpc.com

Name:_____ Age/Sex:_____ Date of Birth:_____
BMI:_____ Neck Circumference:_____ Weight:_____ Height:_____
Referring Physician:_____
What was the reason your physician referred you to have a sleep study performed?_____

Sleep Habits

Check the box for each problem you CURRENTLY HAVE

☐	**Loud Snoring**	☐	**Nightmares**
☐	**Frequent Awakenings at Night**	☐	**Morning Headaches**
☐	**Choking for Breath at Night**	☐	**Morning Dry Mouth**
☐	**Gasping During Sleep**	☐	**Sleepwalking**
☐	**Witnessed Apnea (Been told that you stop breathing)**	☐	**Sleep Terrors**
☐	**Restless Sleep**	☐	**Tongue Biting in Sleep**
☐	**Unrefreshing Sleep**	☐	**Bedwetting**
☐	**Crawling Feeling in Legs when Trying to Sleep**	☐	**Acting out Dreams**
☐	**Leg-kicking During Sleep**	☐	**Feeling Paralyzed when Falling Asleep or Waking Up**
☐	**Leg Cramps in Sleep**	☐	**Dreamlike Images when Falling Asleep or Waking Up**
☐	**Trouble Falling Asleep or Staying Asleep at Night**	☐	**Sudden Weakness when Afraid**
☐	**Racing Thoughts when Trying to Sleep**	☐	**Uncontrollable Daytime Sleep Attacks**
☐	**Increased Muscle Tension when Trying to Sleep**	☐	**Falling Asleep Unexpectedly**
☐	**Fear of Being Unable to Sleep**	☐	**Falling Asleep at Work or School**
☐	**Inability to Fall Back Asleep After Awakening at Night**	☐	**Falling Asleep while Driving**
☐	**Laying in Bed Worrying when Trying to Sleep**	☐	**Recent Changes in Sleep Schedule**
☐	**Waking too Early in the Morning**	☐	**Shift Work Interfering with Sleep**
☐	**Sleep Talking**	☐	**I Use Sleeping Pills to Help me Sleep**
☐	**Sweating a lot at Night**	☐	**I Use Alcohol to Help Me Sleep**
☐	**Waking up with Heartburn or Reflux**	☐	**Pain Interfering with Sleep: Where is the Pain?**
☐	**Waking Up to Urinate**		

Daytime Symptoms & Complaints

Do you nap? ◯ YES ◯ NO

If yes: How often do you nap?_____ Times per week
How long are your naps? _____ Minutes

Do you feel rested and refreshed? ◯ YES ◯ NO

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SLEEP HISTORY
Please provide the following information:

Your Bedtime on WEEKDAYS _____ AM/PM
Time you get up on WEEKDAYS _____ AM/PM
Your bedtime on WEEKENDS _____ AM/PM
Time to get up on WEEKENDS _____ AM/PM

Have you ever had a sleep study before? ◯ YES ◯ NO
If yes: Please indicate where and when you had the study?
_____

Are you a shift worker? ◯ YES ◯ NO
If yes: What kind of shift do you work? _____

Do you currently use CPAP or BIPAP machine at home? ◯ YES ◯ NO
What are your current pressure settings? _____ cm H2O

Are you on home oxygen? ◯ YES ◯ NO
What liter flow of oxygen? _____ liters per minute
Do you use the oxygen for sleep only? ◯ YES ◯ NO

List any current and previous sleep medications you have tried
_____
Please provide the name of your Home Health Company (DME), if applicable
_____

Epworth Sleepiness Scale

Please rate how likely you would be to actually *doze* off during each situation.
Circle a number from 0-3 which best describes each situation and total your answers.
Even if you have not done some of these things recently, try to recall how they would likely affect you.

0 points = Would never fall asleep
1 point = Slight Chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High chance of falling asleep

	Situations	0	1	2	3
A.	Sitting and reading	☐	☐	☐	☐
B.	Watching TV	☐	☐	☐	☐
C.	Sitting, inactive in a public place (Theater, park, meeting...)	☐	☐	☐	☐
D.	As a passenger in a car for an hour without a break	☐	☐	☐	☐
E.	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
F.	Sitting down and talking to someone	☐	☐	☐	☐
G.	Sitting quietly after a lunch	☐	☐	☐	☐
H	In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

TOTAL: _____