**Pulmonary, Critical Care & Sleep Medicine Associates**

10 Office Park Drive, Suite B, Hamilton, OH 45013

**Sleep Medicine Questionnaire**

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please describe your sleep problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How long ago did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please describe any previous evaluation or treatment for this problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List your sleeping hours on a work day? Go to bed \_\_\_\_\_\_\_\_\_\_\_\_am/pm Get up \_\_\_\_\_\_\_\_\_\_\_am/pm
2. List your sleeping hours on non-workdays? Go to bed \_\_\_\_\_\_\_\_\_\_\_\_am/pm Get up \_\_\_\_\_\_\_\_\_\_\_am/pm
3. How long does it usually take you to fall asleep after turning out the lights? \_\_\_\_\_\_\_\_\_\_\_\_ minutes
4. On average, how many times do you wake up during the night? \_\_\_\_\_\_\_\_\_\_\_\_
5. On average how many times do you get up out of bed during the night? \_\_\_\_\_\_\_\_\_\_\_\_
6. If you get up at night, what is the reason that wakes you up or gets you up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you wake up too early in the morning and are unable to return to sleep? Yes No
8. How do you ordinarily awaken? Spontaneously Alarm Clock Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Do you nap? Yes No If so, how many times a week? \_\_\_\_\_\_\_\_\_\_\_\_, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If so, do you find naps refreshing? Yes No

1. Do you find yourself falling asleep when you do not intend to? Yes No
2. Do you ever fall asleep driving? Yes No
3. Have you ever had a sleep study? Yes No If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you snore? Yes No
5. Do you stop breathing while sleeping? Yes No

1. When sitting or lying down, do you have unpleasant or creepy-crawly sensations in your legs (and sometimes in other parts of your body), tied to a strong feeling or urge to move? Yes No

*If you answered yes to 18, please answer the following questions: (If no, please skip to question19)*

1. Do the sensations and urge to move come on during periods of rest or inactivity, and are they relieved by movement? Yes No
2. Do the sensations and urge to move bother you more in the evening and at night, rather than during the day? Yes No
3. Do you have family members who experience these same sensations and urge to move? Yes No
4. Does your bed partner tell you that you jerk your legs (or your arms) when you are asleep; do you sometimes, have involuntary leg jerks when you are awake? Yes No
5. Do you often have trouble falling asleep or staying asleep? Yes No
6. Have you ever suddenly fallen? Yes No
7. Have you ever experienced sudden body weakness brought on by laughter, surprise, or fear? Yes No
8. Have you experienced seeing or hearing things, that were not real, when you were going to sleep or just waking up? Yes No
9. Does anyone in your family have a sleep disorder? Yes No

 If so, who is it, and what kind of sleep disorder is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you ever been told you walk in your sleep? Yes No
2. Have you ever been told you talk in your sleep? Yes No
3. Have you ever been told you have any abnormal behavior during your sleep? Yes No

 If so, please describe the behavior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 dose 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

 Situation: Chance of Dozing:

 Sitting and reading \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Watching TV \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sitting, inactive, in a public place \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 As a passenger in a car for a hour \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lying Down in the afternoon \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sitting and talking to someone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 In a car, while stopped for a few minutes in traffic **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **TOTAL SCORE:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. On average, how many alcoholic beverages do you drink on weekdays? \_\_\_\_\_\_\_ drinks/day
2. On average how many alcoholic beverages do you drink on weekends? \_\_\_\_\_\_\_ drinks/day
3. Do you smoke? Yes No If yes, how many cigarettes, pipes, cigars per day? \_\_\_\_\_\_\_\_\_\_
4. For each of the following, please write the average number that you drink each day:

Coffee \_\_\_\_cups/day; Tea \_\_\_\_cups/day; Carbonated soft drinks “pop” (brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_/day

1. What are your usual working hours? Start \_\_\_\_\_\_\_\_\_\_am/pm Stop \_\_\_\_\_\_\_\_am/pm
2. Please list any medical condition that you have or have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any medications with the dosages that you are currently taking:

 Medication Dosage Medication Dosage

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic to any medicines? Yes No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any surgeries you have had \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your father alive? Yes No If deceased, what did he die of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is your mother alive? Yes No If deceased, what did she die of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please answer the following listed symptoms with yes or no if experienced in the last 2 weeks or more.
4. Loss of interest in things you used to enjoy, including sex. Yes No
5. Feeling sad, blue, or down in the dumps. Yes No
6. Feeling slowed down or restless and unable to sit still. Yes No
7. Feeling worthless or guilty. Yes No
8. Changes in appetite or weight gain. Yes No
9. Thoughts of death or suicide, or suicide attempts. Yes No
10. Problems concentrating, thinking, remembering, or making decisions. Yes No
11. Trouble sleeping or sleeping too much. Yes No
12. Loss of energy or feeling tired all of the time. Yes No
13. Early morning headaches. Yes No
14. Other aches and pains. Yes No
15. Digestive problems. Yes No
16. Feeling pessimistic or hopeless. Yes No
17. Being anxious or worried. Yes No

Thank you for taking the time to fill out this questionnaire. This information will help our physician gain information needed to take care of your medical needs.

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2012 American College of Chest Physicians

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