Community Memorial Hospital
909 W 1st Street P.O. Box 148
Sumner, Iowa 50674
Ph: (563) 578-3275

PT Name________________________
MR# ___________________________
Account #________________________
DOB ___________________________
Provider Name____________________

SLEEP LAB QUESTIONNAIRE

Name:____Age:________Height:_____________

Address:____Gender:______Weight:____________

Telephone Number: ____

Referring Doctor:____Family Doctor: _______________________

How did you hear about our Sleep Center?____

What is the most that you have ever weighed? ________________ lb

What did you weigh **five** years ago? ________________ lb

What did you weigh **one** year ago? ________________ lb

Describe your sleep problem as best as you can:____

____

When did your sleep problem begin? (month, year):____

Have you ever had a sleep study done? □ Yes □ No

If yes, when was it done?______________________ Where was it done?________________________________

What did you find out about the study?____

My ideal hours of sleep during the week are _________ hours.

During the weekend I go to bed at ______AM/PM Get up at _________AM/PM

During the week I usually go to bed at _________AM/PM Get up at _________AM/PM

My bed is a □ Mattress □ Waterbed □ Futon □ Other_____________________________________

My work hours are:____

I can sleep 12 hours or more at a time: □ Nightly □ Weekly □ Rarely □ Never

It usually takes me ________minutes to fall asleep.

I usually wake up ________times at night. What wakes me up:____

____

I cannot get back to sleep when I wake up: □ Nightly □ Weekly □ Rarely □ Never

I snore: □ Nightly □ Weekly □ Rarely □ Never

I started to snore at ___________age.

I snore in all positions: □ Yes □ No

My snoring is: □ Mild □ Moderate □ Very loud

I have trouble breathing through my nose: □ Yes □ No

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Have your bed partner help you answer the following questions. Answer the questions describing a typical night's sleep.

1. I wake up gasping, wheezing, short of breath, or feeling that I cannot breathe:
   □ Nightly □ Weekly □ Rarely □ Never
2. I wake up with a headache:
   □ Nightly □ Weekly □ Rarely □ Never
3. I have been told that I toss and turn:
   □ Nightly □ Weekly □ Rarely □ Never
4. I flail or kick while sleeping:
   □ Nightly □ Weekly □ Rarely □ Never
5. I sleep walk:
   □ Nightly □ Weekly □ Rarely □ Never
6. Immediately after falling asleep, I dream:
   □ Nightly □ Weekly □ Rarely □ Never
7. I talk or scream in my sleep:
   □ Nightly □ Weekly □ Rarely □ Never
8. I grind my teeth when sleeping:
   □ Nightly □ Weekly □ Rarely □ Never
9. I wake up with a sour acid taste in my mouth:
   □ Nightly □ Weekly □ Rarely □ Never
10. I eat my last meal of the day at ____________o'clock.
11. I wake up coughing:
    □ Nightly □ Weekly □ Rarely □ Never
12. I wake up at night with muscle or joint aches and pains:
    □ Nightly □ Weekly □ Rarely □ Never
13. I have strange feelings in my legs. My legs feel restless:
    □ Nightly □ Weekly □ Rarely □ Never
14. I have nightmares:
    □ Nightly □ Weekly □ Rarely □ Never
15. I feel I cannot move after lying down, before going to sleep:
    □ Nightly □ Weekly □ Rarely □ Never
16. I see or hear things that aren't real when lying in bed, but not asleep:
    □ Nightly □ Weekly □ Rarely □ Never
17. After a normal night's sleep, I feel stiff and achy:
    □ Nightly □ Weekly □ Rarely □ Never

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18. After a normal night's sleep, I feel:
    □ Refreshed   □ Fairly rested   □ Somewhat rested   □ Very drowsy
19. I fight sleep or fall asleep unintentionally while sitting (at meetings, watching television, at movies, in the car):
    □ Daily   □ Weekly   □ Rarely   □ Never
20. I fight sleep while driving:
    □ Daily   □ Weekly   □ Rarely   □ Never
21. I have actually fallen asleep while driving a car:
    □Yes   □ No If yes, how often? ________ times.
22. I take daytime naps: □ Yes   □ No If yes, how many naps per day?_____ If no, is there a reason why you do not take naps?   □ No need   □ No time   □ Work/Social situation does not permit naps
23. I dream during my naps:
    □ Nightly   □ Weekly   □ Rarely   □ Never
24. After a nap, I feel:
    □ Refreshed   □ Fairly refreshed   □ Somewhat tired   □ Very drowsy
25. I feel most tired in the:
    □ Mornings   □ Afternoon   □ Evening
26. I feel sudden weakness in my knees, neck, jaw, or arms when angry, sad, laughing, or emotional:
    □ Nightly   □ Weekly   □ Rarely   □ Never
27. I do strange things without knowing it or lose a period of time:
    □ Nightly   □ Weekly   □ Rarely   □ Never
28. It seems that my mood, recall, or thinking has changed: □ Yes   □ No
29. In the last year, depression, worry, or stress has interfered with my sleep: □ Yes   □ No
    If yes, explain:____
    ____
30. My sleep problem has resulted in:____
    ____
    ____
31. Do you exercise? □ Yes   □ No
32. Does anyone in your family have trouble with sleep, snoring, or staying awake in the daytime?
    □ Yes   □ No If yes, please explain:____
    ____
33. I have high blood pressure: □ Yes   □ No
    Do you take any pills for high blood pressure?   □ Yes   □ No
34. I have a history of heartbeat problems: □ Yes   □ No
    Do you take any pills for heartbeat problems?   □ Yes   □ No

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35. I have a history of high/low blood sugar: □ Yes □ No
Do you take any pills for blood sugar? □ Yes □ No
36. I have a history of lung problems: □ Yes □ No
Do you take any pills for lung problems? □ Yes □ No
37. I have a history of arthritis: □ Yes □ No
Do you take any pills for arthritis? □ Yes □ No

Please list your current medications:

Name	Dose/Frequency	Last Taken

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The Epworth Sleepiness Scale

In recent times, rate how sleepy you are with the following. Use the scale to choose the **best number** for 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	______________
Watching TV	______________
Sitting in a public place (movies, meeting)	______________
Rider in a car for an hour with no break	______________
Lying down to rest in the afternoon	______________
Sitting and talking to someone	______________
Sitting quietly after a lunch **without** alcohol	______________
In a car, stopped in traffic for a few minutes	______________
TOTAL	______________

Please list any pills that you have tried to help you sleep:

Medication and Dose	Frequency	Started	Ended

What have you tried to do to help you sleep other than pills?____
____
____

I now smoke ____________cigarettes a day.

My usual amount of coffee, tea, or cola is __________ cups or drinks a day.

I drink alcohol ___________ days per week.

Patient Signature:____Date/Time:________________________

We appreciate that you took the time to fill out this important questionnaire!