Houston Pulmonary, Sleep & Allergy Associates

Sleep Interview Questionnaire

Date: _____ Referring Physician:_____

Last Name: _____ First Name: _____ MI: _____ Male/Female

Marital Status: ___M ___S ___W ___D Religion_____ Race_____

Date of birth: ____/____/_____ Age: ___ SSN: ____-____-____ Occupation_____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Emergency Phone#: _____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

1. What is your main sleep complaint? _____
2. How long has this been a problem? _____
3. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints?_____
4. Have you had a sleep study or home screen? ____ How long ago? ____ Where? _____
5. Have you ever used nasal CPAP or BiPAP? No____ Yes ____
   If so, how long? _____ Pressure setting _____ Mask _____

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

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

Even if you haven't done some of these activities recently, think about how they would have affected you. Use this 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

Situation	**Chance of Dozing**			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3

Total _____

Do you fall asleep or become sleepy when:	**Never**	**Sometimes**	**Often**	**Always**
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3

	Never	Sometimes	Often	Always
5. Suddenly awaken choking or gasping for breath?	0	1	2	3
6. Grind your teeth?	0	1	2	3
7. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
8. How would you rate your overall sleepiness?	0	1	2	3
9. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
1. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
11. Have nightmares?	0	1	2	3
12. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
13. Toss and turn or have restless sleep?	0	1	2	3
14. Walk or talk in your sleep? (Circle appropriate event)	0	1	2	3
15. Snore?	0	1	2	3
16. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
17. Awaken with heartburn or acid reflux? (Acid taste in mouth)	0	1	2	3
18. Wake up with a dry mouth?	0	1	2	3
19. Wake up with headaches?	0	1	2	3
20. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
21. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
22. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
23. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
24. Do you dread getting into bed because you think you will “never” fall asleep?	0	1	2	3
25. How would you rate your overall sleepiness?	0	1	2	3

Section III: Sleep Habits

1. What time do you go to bed on weekdays? _____ Weekends? _____
2. How long does it take you to fall asleep? _____
3. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
4. a.) How often do you awaken at night? _____
   b.) How long do you stay awake? _____
   c.) What reason? (Bathroom, etc.) _____
5. What time do you get up on weekdays? _____ Weekends? _____
6. How many hours of sleep do you get in a typical night? _____
7. How do you feel in the morning?
   ☐ Very sleepy? ☐ Sleepy, but wake up soon ☐ Wide awake, ready to go _____
8. When do you function best?
   Morning: ☐ Best ☐ Medium ☐ Worst
   Afternoon: ☐ Best ☐ Medium ☐ Worst
   Evening: ☐ Best ☐ Medium ☐ Worst

Section IV: Medical History

Please outline your medical history: Do you have or have ever been told you have:

□ High Blood Pressure	□ Elevated Cholesterol	□ Migraine or Frequent Headaches
□ Sinus Problems	□ Stroke	□ Parkinson's
□ Diabetes	□ GI Disease	□ Dementia (Alzheimer's, etc.)
□ Arthritis	□ Cancer	□ Prior History of Sleep Apnea
□ Thyroid Problems	□ Frequent Nighttime Urination	□ Prior History of Restless Legs
□ Anemia	□ Depression and/or Anxiety	□ Obesity
□ Heart Disease	□ Liver Disease	□ Abnormal behavior during sleep
□ Lung Disease	□ Seizures or Epilepsy	

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name	Dosage	Frequency	Reason

1. Your weight? _____ Your height? _____
2. Do you smoke? _____ If yes, how long? _____ How much? _____/ day
3. Do you drink alcohol? _____ If yes, how long? _____ How many drinks? ____/ day/wk/mo
4. Do you drink caffeinated beverages (coffee, tea, soda)? _____ How many drinks? ____/ day/wk/mo

General History

1. Are you having any other problems (e.g. stress, anxiety, or pressures)? If yes, explain:
   _____
2. Have you noticed any changes in your mood or irritability lately? If yes, explain:
   _____
3. Have you been depressed lately? If yes, explain:
   _____
4. Have you had any recent problems with your memory or concentration? If yes, explain:
   _____
5. Do you often travel across time zones, thereby affecting your sleep/wake schedule? If yes, explain:
   _____
6. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)? If yes, explain:
   _____
7. Do you work night shifts and/or rotating shifts? If yes, explain:
   _____

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep:

- □ Loud Snoring
- □ Sitting up in bed while asleep
- □ Twiting of legs or feet
- □ Pauses in breathing
- □ Grinding teeth
- □ Talking in sleep
- □ Rocking or banging head
- □ Kicking legs while asleep
- □ Getting out of bed while asleep
- □ Becoming very rigid and/or shaking
- □ Sleep Walking

How long have you been aware of the sleep behaviors that you have checked above?

_____
_____
_____

Describe the behaviors checked above in detail. Include the description of activity, time it occurs, frequency during the night and whether it happens every night.

_____
_____
_____
_____
_____

Any additional comments:

_____
_____
_____
_____
_____