St. Louis Heart and Vascular - McKelvey Office
www.slhv.com

Phone: 314-741-0911
Fax: 314-741-0501

Name: Patient Test **PID:** 6862727
DOB: 01/01/1962

Sleep Study Questionnaire

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

Today's Date: _____

My Main Sleep Complaint(s) Is:

- ❑ Trouble sleeping at night For how many months/years_____
- ❑ Being sleepy all day For how many months/years?_____
- ❑ Snoring For how many months/years?_____
- ❑ Unwanted behaviors during sleep, explain: _____
- ❑ Other, explain: _____

Sleep Pattern

	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____ a.m./p.m.

	Work Days (Weekday)	Off Days(Weekends)
How do you usually awaken, i.e., alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____ a.m./p.m.

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Total amount of sleep per night: _____ _____

Number of naps per day:_____ _____

Please check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I have been unable to sleep at all for several days
- ❑ I feel that I have insomnia
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I have slept for several days at a time, or at least I have felt overwhelmingly sleepy for that long
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ My snoring or breathing is much worse if I drink alcohol prior to falling asleep
- ❑ I have problems with nasal congestion when I am trying to fall asleep (blockages, allergies, infections)
- ❑ I have been awakened by my own snoring
- ❑ I use supplemental oxygen at night (____LPM)

Restlessness

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- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep
- ❑ At night my heart pounds, beats rapidly, or beats irregularly

Disposition

- ❑ At bedtime, I feel sad or depressed
- ❑ My sleep is disturbed by sadness or depression
- ❑ I am unhappy about the loving relationships in my life
- ❑ I have considered or attempted suicide
- ❑ Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"
- ❑ My desire or interest in sex is less than what it used to be

Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I often have to let someone else drive because I am too sleepy to drive
- ❑ Sometimes I realize I have driven to the wrong place, but can't remember how I got there
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I am very sleepy during the day and I struggle to stay awake
- ❑ I perform poorly at my job because of sleepiness or fatigue
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

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Habits

Do you smoke? ❑ Yes ❑ No

If Yes:	What?	Amount per Day	For How Many Years
	❑Cigarettes	_____ pack(s)	_____ years
	❑Cigars	_____ cigars	_____ years
	❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes:	What?	Frequency			Amount per Week
	❑Beer	❑Daily	❑Weekends	❑Rare	_____cans/week
	❑Wine	❑Daily	❑Weekends	❑Rare	____glasses/week
	❑Liquor	❑Daily	❑Weekends	❑Rare	_____shots/week

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status: ❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker
- ❑ I am currently a student

Vital Statistics

What is your: Height? ____ feet _____inches Weight? _____ pounds Neck Size:_____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Current Medications

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day

Allergies: _____

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Past Sleep Evaluation and Treatment

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

Past Medical History

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Cancer
- ❑ Thyroid problems
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems
- ❑ Erectile dysfunction/impotence

List other past medical problems and dates:

_____ _____

_____ _____

_____ _____

List Surgeries and the year

_____ _____

_____ _____

_____ _____

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Check any of the following symptoms you have had in the past 12 months:

- ❑ Frequent headaches
- ❑ Fainting or passing out
- ❑ Sudden loss of vision or strength
- ❑ Inability to speak
- ❑ Hearing loss or ringing in ear(s)
- ❑ Hoarseness for more than 2-4 weeks
- ❑ Nosebleeds
- ❑ Cough for more than 2-4 weeks
- ❑ Coughing up blood
- ❑ Shortness of breath or wheezing
- ❑ Swelling in feet or ankles
- ❑ Chest pain, tightness or pressure
- ❑ Irregular or sudden, fast heartbeat
- ❑ Difficulty swallowing or food "sticking"
- ❑ Frequent heartburn / indigestion
- ❑ Abdominal pain
- ❑ Frequent constipation
- ❑ Frequent diarrhea
- ❑ Rectal bleeding / black stools
- ❑ Difficulty urinating / incontinence
- ❑ Blood in urine
- ❑ Urinating more than 2 times per night
- ❑ Pain in joints or bones
- ❑ Unusual bruising or bleeding
- ❑ Epilepsy / seizures
- ❑ Change in wart, mole or skin growth
- ❑ Weight loss of more than 5-10 lbs.

Family History
Has an immediate blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation
❑	❑	Cancer	_____	❑	❑	Stroke	_____
❑	❑	Diabetes	_____	❑	❑	Anxiety/Depression	____
❑	❑	Hypertension	_____	❑	❑	Sleep Apnea	_____
❑	❑	Heart disease	_____	❑	❑	Narcolepsy	_____
❑	❑	Thyroid disease	_____	❑	❑	Other:	_____ _____

Epworth Sleepiness Scale:
Use the following scale to choose the most appropriate answer for each of the following situations:

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place (theater, meeting, etc)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when able	0 1 2 3
Sitting and talking to someone	0 1 2 3

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Sitting quietly after a lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3
TOTAL	___/24

Conclusion

1. Do you feel that your sleep or daytime alertness is abnormal? _____
2. What is your personal interpretation as to why you have your particular sleep/wake problem? Please describe:

_____
_____
_____
_____

Please check through the questionnaire to see if you have answered all the questions.

Bed Partner Questionnaire

Name of the patient: _____ Date: _____

Name/Relationship of person filling out this form: _____

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency it occurs and whether it happens every night:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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Has this person ever fallen asleep during normal daytime activities or in dangerous situations? _____ If yes please explain:

_____

_____

_____

_____

_____

_____

Do you have concerns with this person's:	Yes	No
breathing at night?	_____	_____
restlessness during sleep?	_____	_____
sleepwalking/talking?	_____	_____
becoming very rigid or shaking during sleep?	_____	_____