Shasta Critical Care Specialists
Sleep Center: (530) 232-3017, 2701 Old Eureka Way, **Suite 1J**, Redding, CA 96001
Office: (530) 232-3000, 2701 Old Eureka Way, Suite 1E, Redding, CA 96001

Fax: (530) 242-8545

SLEEP-WAKE QUESTIONNAIRE

This questionnaire is for patients 18 years of age or older that have a scheduled appointment at the Sleep Center. It will take approximately 20 to 30 minutes to complete. The information you provide is very important and will assist the sleep specialist during the review of your sleep symptoms. Please respond to all questions by checking the appropriate box, encircling the provided responses, or completing the free text sections.

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: _____

Scheduled Appointment Date: _____ Sleep Specialist: _____

Height (inches): _____ Weight now (lbs): _____

Weight 1 year ago:_____ Weight 5 years ago:_____

Marital Status: _____ Number of Children:_____

I was referred by: Name of Doctor:_____

Other: _____

Specific issues I want to discuss at my appointment (please, list in order of concern):

1. _____

2. _____

3. _____

1. SLEEP SCHEDULE

What time do you go to bed on weekdays? _____ a.m. p.m.

What time do you go to bed on weekends? _____ a.m. p.m.

What time do you get out of bed on weekdays? _____ a.m. p.m.

What time do you get out of bed on weekends? _____ a.m. p.m.

How much sleep do you get on an average night (hours)?

Are you... A morning Type, An evening Type, Neither evening or morning type

What would be your ideal bedtimes? (from _____(a.m./p.m.) to _____(a.m./p.m.))

Do you nap? No Yes

How often do you nap? (number of times per week) _____

How long are the naps? (in minutes) _____

Do you awaken refreshed from the nap? No Yes

What are your usual work hours? _____

Are you a shift worker? No Yes

If yes, what kind of shift do you work (hours)? _____

What is (was) your occupation? _____

If retired, when? _____

2. SLEEP HISTORY

Do you have difficulty falling asleep? No Yes

Do you have difficulty staying asleep? No Yes

Do you wake up too early and cannot get back to sleep? No Yes

Do you have thoughts racing through your mind that make it difficult to sleep? No Yes

How long does it take you to fall asleep at night (minutes)? _____

Do you read in bed? No Yes

Do you watch TV in bed? No Yes

Do you share the bed with anyone? No Yes

Does your partner have a sleep disorder? No Yes

Do you have pets sleep in the bedroom? No Yes

Is your bedroom comfortable? No Yes

If no, please describe _____

How many times do you wake up during the night? _____

How long does it take you to fall asleep again (minutes)? _____

Do you have unpleasant feelings of fear, anxiety, tension, or unhappiness waking you up? No Yes

Do you have feelings of muscle tension or tightness in your arms or chest? No Yes

Do you have pain or joint discomfort? No Yes

Do you have other problems waking you up? No Yes

If yes, please describe: _____

In the morning, do you wake up: Wake up naturally, With an alarm, Both

In the morning, do you wake up feeling: Refreshed, Sleepy/Groggy, Tired

3. ABNORMAL MOVEMENTS/BEHAVIORS

Do you have or have you ever experienced:

An urge to move your legs, usually accompanied by uncomfortable and unpleasant sensations in the legs? No Yes

Discomfort in the legs that worsen during periods of rest or inactivity such as laying down or sitting? No Yes

Discomfort in the legs that is relieved by movement: walking or stretching? No Yes

Discomfort that worsens during the nighttime? No Yes

Do you have leg cramps (Charley horse)? No Yes

Do you kick, punch, or poke your bed partner while asleep? No Yes

If yes, have you ever injured your bed partner or yourself? No Yes

Do you grind your teeth? No Yes

Do you wear a bite splint (mouth guard)? No Yes

Do you walk in your sleep? No Yes

If yes, when was the last time? _____

Do you talk in your sleep? No Yes

Do you have nightmares or night terrors? No Yes

If yes, please describe the behavior, including the time of night and how frequently?

_____

_____

Have you acted out your dreams? No Yes

Do you make rolling movements or bang and twist your head at night? No Yes

Have you had sleep problems as a child? No Yes

If yes, please describe

_____

_____

4. DAYTIME SLEEPINESS

Have you fallen asleep unexpectedly? No Yes

Have you ever had an accident or near-miss because
you have fallen asleep while driving? No Yes

If yes, when? _____

Do you kick or jerk your arms or legs during sleep? No Yes

Are your bed covers messy in the morning? No Yes

Have you ever experienced sudden muscle weakness when you laugh,
listen to a joke, are surprised or angry? No Yes

If yes, during your episode of muscle weakness. If no, please skip to the next question.

a) Can you hear? No Yes
b) Does your speech ever become slurred? No Yes
c) c) Is your head affected? No Yes
d) d) Is your whole body affected? No Yes
e) e) How long does the weakness usually last? _____

Have you experienced dreamlike images or sounds
while falling asleep or waking up? No Yes

Have you experienced an inability to move while falling asleep or waking up?	No	Yes

5. SNORING/BREATHING HISTORY

Do you snore?	No	Yes
What is your preferred sleep position (% of the time in each)?		
Back (% of sleep time)	_____	
Left Side (% of sleep time)	_____	
Right Side (% of sleep time)	_____	
Stomach (% of sleep time)	_____	
Does your sleep position affect your snoring?	No	Yes
Do you awaken choking or short of breath?	No	Yes
Do you awaken with a snort or gasping for air?	No	Yes
Has anyone noticed you stop breathing while asleep?	No	Yes
Do you awaken often to urinate during the night?	No	Yes
Do you awaken with acid or sour taste in your mouth?	No	Yes
Do you have difficulty breathing while on your back?	No	Yes
Do you avoid sharing a room because of snoring?	No	Yes
Do you sweat excessively during the night?	No	Yes
Do you awaken with a dry mouth or sore throat?	No	Yes

6. MEDICAL/SURGICAL HISTORY

Have you ever had a sleep study in the past? No Yes

If yes, when?_____If yes, where?_____

Do you use CPAP or BiPAP at home? No Yes

If yes, what pressure setting? _____

Do you use oxygen at home? No Yes

If yes, what Liter/flow setting? _____

Have you ever had tonsils or adenoids removed? No Yes

Have you ever had sinus or nasal surgery? No Yes

Have you ever broken your nose? No Yes

Have you ever had any type of head injury? No Yes

Have you ever had surgery to promote weight loss? No Yes

If yes, when? _____

Have you had dental surgery or orthodontics? No Yes

If yes, Please describe: _____

Please check the appropriate box if you have a history of any of the following:

- o Hypertension
- o Congestive Heart Failure
- o Heart attack
- o Cardiac arrhythmias
- o Stroke/TIA
- o Thyroid disease
- o Lung Problems /COPD/Asthma
- o Pulmonary Hypertension
- o Diabetes
- o Parkinson's
- o Anemia/Iron deficiency
- o Heartburn/Reflux
- o Arthritis
- o Sexual dysfunction/loss of libido
- o Fibromyalgia
- o Depression/Anexiety
- o Seizures
- o Menopause
- o Frequent blood donations
- o Connective tissue disease (e.g. Lupus)
- o Cancer
- o Nasal allergies /congestion
- o End stage kidney disease/dialysis
- o Other

If other, please specify

_____

_____

_____

7. FAMILY HISTORY

Does any member of your family have any of the following?

Snoring or Sleep apnea?	No	Yes
If yes, Relationship	_____	
Narcolepsy?	No	Yes
If yes, Relationship	_____	
Seizure disorder?	No	Yes
If yes, Relationship	_____	
Depression?	No	Yes
If yes, Relationship	_____	
Hypertension, heart disease, heart failure?	No	Yes
If yes, Relationship	_____	
Stroke?	No	Yes
If yes, Relationship	_____	
Diabetes?	No	Yes
If yes, Relationship	_____	

8. ALLERGIES

Please list any known medication or environmental (pets, pollens, food, etc.) allergies

Allergies:

_____
_____
_____
_____
_____
_____
_____

9. MEDICATIONS

List current medications (give medication name, dose, and number of time taken per day), including OTC and vitamin/herbal supplements.

Medication Name	Dose	Number of time taken per day

10. SOCIAL HISTORY

Do you use tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipe)? No Yes

If yes Packs per day?_____ If yes, when did you start? _____

If yes - quit, when did you quit? _____

Do you drink alcohol? No Yes

If yes, how many drinks? _____per Day Week Month

Do you drink caffeinated beverages? No Yes

If yes, how many cups (8 oz.) per day? _____

Do you use recreational drugs? No Yes

Do you exercise? No Yes

11. BED PARTNER, PARENT OBSERVATION QUESTIONNAIRE

Do you live with the patient?	No	Yes
Do you sleep in the same room as the patient?	No	Yes
If no, is it because of his/her sleep behaviors (i.e. snores too loud acts out dreams, etc)?	No	Yes

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

- o Loud snoring
- o Light snoring
- o Pauses in breathing
- o Grinding teeth
- o Twitching of legs or feet during sleep
- o Sleep-talking
- o Sleepwalking
- o Head rocking or banging
- o Bedwetting
- o Sitting up in bed but not awake
- o Kicking with legs during sleep
- o Biting tongue
- o Getting out of bed but not awake
- o Becoming very rigid and/or shaking

How long have you been aware if the sleep behavior(s) _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

_____
_____
_____
_____

Name of person completing this form: _____

Relationship to patient: _____