Beebe–Pulmonology & Sleep Disorders
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INITIAL SLEEP QUESTIONNAIRE

(To be completed by patient)

NAME:_____ **DATE:**_____

Please consult your spouse/bed partner when answering the following questions. Answer questions as it best describes a typical night or sleep pattern. Thank you.

1. Please describe your main complaint:_____

   _____

2. When did your sleep problem begin:_____
3. Have you ever had a sleep study before? YES_____ NO_____
   If yes, where & when was the test performed:_____
   What were the results?_____
4. a). During the week I usually:
   Go to bed at:_____(time)
   Get up at:_____ (time)
   Sleep a total of:_____(hours)

   4b). During the weekend I usually:
   Go to bed at:_____ (time)
   Get up at:_____(time)
   Sleep a total of:_____ (hours)
5. It usually takes me _____minutes to fall asleep.
6. I usually wake up _____time(s) during the night.
   Please explain what wakes you up:_____

   _____

   What is your typical length of time, with each awakening? _____
7. Tonsils: Present Absent (Please circle one)

8. **PLEASE CIRCLE YOUR CHOICE REGARDING THE INDICATED PROBLEM**:

1 = Never; 2 = Almost Never; 3 = Sometimes; 4 = Almost Always; 5 = Always

1 2 3 4 5	Snoring
1 2 3 4 5	Awakening others as a result of snoring
1 2 3 4 5	Awakening from sleep with choking or gasping
1 2 3 4 5	Snoring more loudly on your back than on your side
1 2 3 4 5	Gaps or pauses in breathing during sleep
1 2 3 4 5	Waking up with a headache in the morning
1 2 3 4 5	Waking up with dry mouth in the morning
1 2 3 4 5	Waking up with sour taste in the mouth
1 2 3 4 5	Feeling unrefreshed after a full night's sleep
1 2 3 4 5	Falling asleep in boring situations during the day
1 2 3 4 5	Falling asleep while reading or watching television
1 2 3 4 5	Falling asleep or nodding off while driving
	Have you had an accident or a near miss due to falling asleep while driving? If YES, please describe the circumstances:_____
	_____
1 2 3 4 5	Kicking or leg twitching during the night
1 2 3 4 5	Leg discomfort prior to or after falling asleep. If so, please describe:
	_____
1 2 3 4 5	Other body movements during sleep. If so, please describe:_____
	_____
1 2 3 4 5	Sleep walking
1 2 3 4 5	Nightmares or vivid dreams
1 2 3 4 5	Tooth grinding or clenching
1 2 3 4 5	Paralysis during sleep or just prior to sleep
1 2 3 4 5	Sudden loss of muscle control while awake
1 2 3 4 5	Sudden weakness following an emotional experience
1 2 3 4 5	Dream during day time naps
1 2 3 4 5	Difficulty falling asleep
1 2 3 4 5	Difficulty staying asleep with waking up during the night
1 2 3 4 5	Awakening early in the morning even though you don't have to
1 2 3 4 5	Tension which increases as bedtime approaches.

SOCIAL HISTORY:

Do you drink caffeinated beverages? YES_____ NO_____

If yes, how many cups or cans per day?_____

Do you consume alcohol? YES_____ NO _____

If yes, how often? DAILY _____ WEEKLY _____ MONTHLY _____

THE EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations? This refers to your normal activities of daily living. Use the following scale to choose the appropriate number for each situation listed below:

0 = Would never dose off. 1 = Slight chance of dozing. 2 = Moderate chance of dozing.
3 = High chance of dozing.

SITTING & READING	_____
WATCHING T.V.	_____
SITTING IN PUBLIC	_____
IN A CAR FOR AN HOUR	_____
LYING DOWN IN THE AFTERNOON	_____
SITTING & TALKING TO SOMEONE	_____
SITTING AFTER LUNCH	_____
SITTING IN TRAFFIC AS A PASSENGER	_____
TOTAL:	_____

FAMILY HISTORY: Please list all relatives who suffer from:

Insomnia:_____

Sleep Apnea:_____

Day Time sleepiness:_____

Narcolepsy:_____

Other sleep disorders:_____

WEIGHT HISTORY: **CURRENT WT:_____; 1 YEAR AGO:_____; 5 YEARS AGO:_____**

REVIEW OF SYMPTOMS: Please circle any of the following that apply to you:

Headaches	Depression	Feel tense	Sexual problems
Bowel Disturbance	Palpitations	Tremors	Insomnia
Fatigue	Memory disturbances	Dizziness	Fainting spells
Postnasal Drip	Shortness of breath	Wheezing	Chest pain
Leg Swelling	Joint pains	Back pain	Skin rash
Seizures	Nausea	Vomiting	Abdominal pain
Fever	Weakness	Blurred vision	