The Lung Center and Sleep Clinic
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Adult Questionnaire – Ages 15+

Please fill out this questionnaire and bring it with you when you come in for your appointment.
IMPORTANT: This questionnaire must be completed with as much detail as possible.

Your Full Name_____ Your Doctor_____

Height _____ Weight_____ Collar size_____ Date of Birth_____ Sex M F

Please write down a brief description of your sleep problem or why you are having this test.

_____

_____

_____

_____

How long have you had this problem? _____

Is it affecting your daily activities? If so, how? _____

_____

How serious do you feel this problem is? (Not at all) (A little) (Fairly serious) (Serious) (Very serious)

Please list your current prescription and nonprescription medications.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you now or have you ever used any medication to help you sleep? Yes No

If so what is (or was) the medication? _____ Did it help? Yes No

Have you ever had any of the following health problems?

Mental Health	Yes	No	Comment_____
Eyes/Ears/Nose/Mouth/Throat	Yes	No	Comment_____
Heart/Circulatory	Yes	No	Comment_____
Breathing(lungs)	Yes	No	Comment_____
Stomach(digestive)	Yes	No	Comment_____
Urine/Kidney	Yes	No	Comment_____
Bone or joint problem	Yes	No	Comment_____
Diabetes/Glands	Yes	No	Comment_____
Blood pressure	Yes	No	Comment_____
Weight problem	Yes	No	Comment_____
Sexual problem	Yes	No	Comment_____

What is your normal bedtime during the week? _____. What is your normal time to get up? _____.

On weekends what is your normal bedtime? _____. On weekends what time do you get up? _____.

On the average, how many caffeinated beverages do you drink in a day?

(Please include coffee, tea and soft drinks etc.) _____

How many alcoholic beverages do you drink in a day? _____

If you smoke, how much do you smoke per day? _____

Have you had a sleep study done before? Yes No

If yes, when did you have it done? _____. Where was it done?_____

Do you know the results? If so, please describe. _____

_____

_____

Do you have a regular bed partner? Yes No

If so, what do they say about your sleeping patterns?

_____

_____

_____

_____

How long does it usually take for you to fall asleep when you turn out the lights? _____

What do you usually do just before going to bed? (such as watch TV, read etc.) _____

_____

How often do you awaken during the night? _____

Do you at times awaken too early, unable to go back to sleep? Yes No

How long do you usually sleep at night?_____

How do you ordinarily awaken? (Alarm clock) (Spontaneously) (Other)

How hard is it for you to get up and around? (Very hard) (Hard) (Sometimes hard) (No problem)

Do you take naps regularly? Yes No

If so, at what time of day do you take naps? _____

How long are these naps? _____

Do you feel you are getting enough sleep? Yes No

Do you think you are sleeping too much? Yes No

Have you ever experienced a sudden overall weakness or fallen suddenly without tripping? Yes No

Patient Name:_____ DOB:_____

If yes, when this occurred, were you aware of your surrounding? Yes No

Did this seem to be brought on by anything? Yes No

Explain_____

_____

Have you ever experienced weakness or paralysis,

Upon going to sleep Yes No Upon awakening from sleep Yes No

Have you ever experienced dreamlike activity (such as, seeing things or hearing things that aren't real)

Upon going to sleep? Yes No During the night? Yes No

Upon awakening? Yes No During the day? Yes No

Do you have trouble breathing while sleeping? Yes No

If yes, please explain briefly _____

_____

Do you snore? Yes No

Does your snoring disturb your bed partner? Yes No

Does it disturb someone in another room? Yes No

How long have you snored?_____

Do you experience restless, twitching, or crawly feelings while you are asleep? Yes No

Has anyone told you your arms or legs twitch or jump while you are asleep? Yes No

If yes to either question, how many nights in the week does this occur? _____

Are you able to relieve this sensation? Yes No

If so, what helps? _____

How long has this bothered you?_____

Do you know or do others tell you if any of the following occurs during your sleep period?

Talk in your sleep? Yes No How often_____

Walk in your sleep? Yes No How often_____

Grit your teeth? Yes No How often_____

Wet the bed? Yes No How often_____

Wake up screaming or afraid? Yes No How often_____

Make unusual movements? Yes No How often_____

Awaken with headaches? Yes No How often_____

EPPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these activities recently, how likely do you think you would be to doze off in these situations? Use the following 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.

____ Sitting and reading

____ Watching TV

____ Sitting inactive in a public place (e.g. theater, church, a meeting)

____ A passenger in a car for an hour without a break

____ Lying down to rest in the afternoon when circumstances permit.

____ Sitting and talking to someone

____ Sitting down after lunch

____ In a car while stopped for a while in traffic (e.g. traffic light)

Score_____

STOP-BANG

Answer each of the following yes or no:

1. Do you **SNORE** loudly
   (louder than talking or loud enough to be heard through closed doors)? _____
2. Do you often feel **TIRED**, fatigued, or sleepy during daytime? _____
3. Has anyone **OBSERVED** you stop breathing during your sleep? _____
4. Do you have or are you being treated for high blood **PRESSURE**? _____
5. **BMI** more than 35? _____
6. **AGE** over 50 years old? _____
7. **NECK** circumference greater than 15.75 inches? _____
8. Male **GENDER**? _____

Score _____

Patient Signature:_____ Date:_____

Technician Notes:

Technician Signature:_____ Date:_____

Patient Name:_____ DOB:_____