Patient Sleep Questionnaire

Patient's Name: _____ Date: _____

1. **Have you been told your breathing stops while asleep? YES NO**
2. **Approximately how many times per night do you wake up? _____**
3. **How many hours of sleep do you get per night? _____**
4. **Do you wake up feeling un-refreshed? YES NO How often? _____**
5. **Do you wake up with a headache? YES NO How often? _____**
6. **Do you feel sleepy during the day? Always Sometimes Occasionally**
7. **Do you get sleepy when driving? YES NO**
8. **Are you less alert than you would like to be during the day? YES NO**
9. **Do you have any loss of memory? YES NO Depression? YES NO**
10. **Do you have high blood pressure? YES NO Heart irregularities? YES NO**
11. **Present weight? _____Height? _____Neck/collar size? _____**
12. **Have you gained weight recently? YES NO How much? _____**
13. **Do you have difficulty breathing through your nose? YES NO**
14. **Do your jaw joints click? _____ Stick? _____ Hurt? _____**
15. **Have you had a sleep study done? YES NO How long ago? _____**
16. **Does pain interfere with your sleep? YES NO**
17. **Have you ever fallen asleep while you were behind the wheel of a motor vehicle? YES NO**
18. **Do you have a family history of sleep apnea? YES NO**
19. **Do you have any lung or breathing problems? YES NO**

    If yes, please describe. _____
20. **Do you have a Pacemaker? YES NO**
21. **Do you use oxygen at night? YES NO**
22. **Have you ever had oral or nasal surgery? YES NO**

    If yes, please describe. _____
23. **Do you drink alcohol? How often? (Circle all that apply)**

    Daily 3-5 times a week once a week only on weekends on special occasions

BRIEFLY DESCRIBE YOUR SLEEP CONCERNS:

_____

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Epworth Sleepiness Scale

Name: _____ **Date:** _____

Your age: _____ **Your sex:** ☐ Male ☐ Female

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

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

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

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As 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 quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:
0-10 Normal range
10-12 Borderline
12-24 Abnormal

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CPAP INTOLERANCE (CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section

I could not tolerate the CPAP device due to:

- ☐ Mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ disturbed or interrupted sleep caused by the presence by the presence of the device
- ☐ Noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip causing tooth related problems
- ☐ A latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night

Other:_____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

Patient Signature: _____Date:_____

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