Sleep Study Questionnaire

Once you’ve scheduled your appointment, please complete the sleep study questionnaire and fax or mail to our main office. If you have any questions, please contact us during office hours at 904.202.1632.

Fax to: 904.202.4951
Mail to:
Sleep Disorder Center
836 Prudential Drive
Jacksonville, FL 32207

DEMORAPHIC INFORMATION:

Patient’s name: _________________________  _________________________  ______ Date of birth: ________________
Last                                             First                              MI

Home address: ______________________________________________________________________________________
Street                                                   City                                         State                         Zip Code

Home phone: _________________________ Work: _________________________ Cell: _________________________

Sex: _____      Age: _____      Height: _____      Weight: _____lbs.      Neck size: _____     Claustrophobic ______

Name of physician ordering sleep study: _______________________________________________________________
Referring physician’s address: _________________________________________________________________________
Referring physician’s phone number: ____________________________ Fax number: _________________________

Check either “yes” or “no” for the following questions:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Insomnia</td>
<td></td>
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<tr>
<td>Snoring</td>
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<tr>
<td>Not breathing / nocturnal choking</td>
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<td>Obesity</td>
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<td>Restorative sleep</td>
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<tr>
<td>Excessive daytime sleepiness</td>
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<td>Drugs / alcohol / prescribed narcotics and sedatives</td>
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</table>
Please respond to the following questions to the best of your ability. If you have a bed partner, please have him/her answer the questions about YOUR sleeping habits.

<table>
<thead>
<tr>
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<th>Patient’s Response</th>
<th>Partner’s Response</th>
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<tbody>
<tr>
<td>1.</td>
<td>How long have you had a problem with your sleep?</td>
<td>______________________</td>
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<td>2.</td>
<td>How many nights per week do you have sleeping problems?</td>
<td>______________________</td>
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<td>3.</td>
<td>How many hours do you sleep a night?</td>
<td>______________________</td>
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<td>4.</td>
<td>How many times do you awaken at night?</td>
<td>______________________</td>
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<td>5.</td>
<td>How long are you awake on average?</td>
<td>______________________</td>
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<td>6.</td>
<td>How long does it take you to fall asleep?</td>
<td>______________________</td>
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<td>7.</td>
<td>Do you have leg pain when trying to fall asleep?</td>
<td>______________________</td>
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<td>8.</td>
<td>Does your leg pain (aching, cramping, sensation that you have to move your legs) awaken you during the night or prior to sleep?</td>
<td>______________________</td>
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<td>9.</td>
<td>Do you have any unusual sleep habits?</td>
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<td>If yes, please describe: __________________________________________________________________________</td>
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<td>10.</td>
<td>Are you currently a shift worker?</td>
<td>______________________</td>
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<td>If yes, please describe your occupation: ____________________________________________________________</td>
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How many ounces of the following beverages or foods do you consume daily?
Coffee:______ Caffeinated soft drinks:______ Tea:______ Alcoholic beverages:______ Chocolate:______

Please rate yourself during the following situations using the scale below (1-5):
1 – No problem, never occurs
2 – Mild problem, rarely occurs
3 – Moderate problem, happens occasionally
4 – Moderately severe problem, occurs often
5 – Severe problem, occurs regularly

Rate how the following situations affect your sleep:
____ Sleeping in an unfamiliar bed?
____ Asthma?
____ Coughing?
____ Difficulty breathing while lying flat?
____ Reflux / regurgitation? (burning in the throat)
____ Frequent need to urinate?
____ Nasal congestion?
____ Pain in your legs?
Please rate yourself during the following situations using the scale below (1-5):
1 – No problem, never occurs
2 – Mild problem, rarely occurs
3 – Moderate problem, happens occasionally
4 – Moderately severe problem, occurs often
5 – Severe problem, occurs regularly

Rate the difficulty you have with the following:
_____ Daytime sleepiness, dozing off or struggling to stay awake?
_____ Fatigue or exhaustion during the day?
_____ Snoring?
_____ Falling asleep at inappropriate times during the day?
_____ Work/studies compromised because of fatigue or sleepiness?
_____ Falling asleep while operating a motor vehicle?
_____ Accidents as a result of falling asleep while driving?
_____ Feeling sleepy / fatigued?
_____ Feelings of weakness after a surprise or emotional change?
_____ Daytime hallucinations or dreaming?
_____ Not being able to move when first waking up, despite the feeling of being awake?
_____ Holding your breath, stopping breathing or making gasping sounds when sleeping?
_____ Gasping for air or feeling unable to breath when waking?

Please place an “X” by any of the following that apply to you:
_____ Nightmares  _____ Palpitations  _____ Feelings of panic
_____ Unable to relax  _____ Bowel disturbance  _____ Fainting
_____ Headaches  _____ Dizziness  _____ Tense feelings
_____ Poor memory  _____ Depression  _____ Difficulty with decisions
_____ Shyness  _____ Insomnia  _____ Suicidal thoughts
_____ Anxiety  _____ Stomach problems

Do you have any other issues that interrupt your sleep? ________________________________________________

____________________________________________________________________________________________________

Is there any additional information pertinent to your sleep evaluation that you feel is important to explain?
____________________________________________________________________________________________________

____________________________________________________________________________________________________

Do you currently use home oxygen? _______
If yes, how many hours a day? _______  Daytime? _______  Nighttime? _______
Medical History

Please list any chronic medical illnesses diagnosed by a physician that you have (i.e. diabetes, hypertension, incontinence, etc.)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Medications (prescription and over-the-counter)

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<th>Medication</th>
<th>Purpose</th>
<th>Time of day</th>
<th>Dosage</th>
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Patient Signature: ______________________________

Below to be completed by Sleep Center physician or designee

Questionnaire review by: ___________________________ Date: ___________ Time: __________
Test to be performed: RT _____ CPAP _____ SPLIT _____ MSLT _____ MWT _____
Special instructions: ________________________________________________________________
________________________________________________________________________________