Northwestern Medicine®
Sleep Disorders Center

PATIENT SLEEP QUESTIONNAIRE

Patient name:______________________________ Referring physician:______________________________

Height: ______________________________ Usual bedtime: ____________________ AM PM

Weight:______________________________ Usual rise time: ____________________ AM PM

Neck circumference: ______________________

PAST SLEEP MEDICAL HISTORY

Why did your doctor ask you to have this test?

____

What is your expectation of what will be done during this test? Is this test for observation or will you be using a PAP or dental device?

____

Have you had a sleep evaluation before? ☐ No ☐ Yes
If yes, when and where?

____

Have you been diagnosed with sleep apnea? ☐ No ☐ Yes

Do you currently use a CPAP or BIPAP machine? ☐ No ☐ Yes

If yes, where did you get your machine? What is your current pressure and settings?

____

Do you currently use a dental device for OSA? ☐ No ☐ Yes

If yes, where did you get your device? What are your current settings?

____

Do you take medication to help you sleep? ☐ No ☐ Yes

If yes, what?

____

Are you a shift worker? ☐ No ☐ Yes

If yes, what hours do you normally work?

____

CURRENT MEDICATIONS

Please list all prescription and non-prescription drugs including vitamins and sleep aids

____

____

____

CHECK ALL THAT APPLY:

- ☐ I feel sleepy during the daytime
- ☐ I have been told I snore
- ☐ I have been told I stop breathing in my sleep
- ☐ I wake up gasping or short of breath
- ☐ I wake up at night coughing
- ☐ I get up more than once to use the bathroom
- ☐ I sometimes awaken with headaches
- ☐ I am hoarse or have a sore throat in the morning
- ☐ I wake up in the morning feeling unrefreshed
- ☐ I breathe mainly through my mouth
- ☐ I have difficulty breathing through my nose
- ☐ I have gained more than 20 lbs over the last 2 years
- ☐ I have difficulty falling asleep
- ☐ I wake up during the night and can't get back to sleep
- ☐ I wake up thrashing or hitting and have hurt myself or my partner
- ☐ I act out my dreams
- ☐ I sleep walk
- ☐ I sleep talk
- ☐ I sleep eat (eating while asleep)
- ☐ I do unusual things in my sleep (For example: ____)
- ☐ I grind my teeth when I sleep
- ☐ I wear a mouth guard for teeth grinding
- ☐ Sometimes I feel uncomfortable sensations in my legs at night and feel like I just have to move them
- ☐ I have been told that I kick at night
- ☐ I have experienced vivid dream-like scenes upon falling asleep
- ☐ I have experienced vivid dream-like scenes upon waking up
- ☐ Sometimes I feel unable to move when I'm waking up or falling asleep
- ☐ When I'm angry, surprised, or laugh, I feel like I'm going limp or about to fall

PAST MEDICAL HISTORY (check all that apply)

- ☐ Heart disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Pulmonary hypertension
- ☐ Stroke
- ☐ Parkinson's
- ☐ Alzheimer's disease
- ☐ ADHD
- ☐ ALS
- ☐ Depression
- ☐ Acid reflux / GERD
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Emphysema / COPD / Lung disease
- ☐ Epilepsy / seizures
- ☐ Asthma
- ☐ Other____________________________

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Do you smoke? ☐ No ☐ Yes If yes, list amount and how often:

____

Do you consume alcohol? ☐ No ☐ Yes If yes, list amount and how often:

____

PAST SURGICAL HISTORY (check all that apply)

- ☐ Bariatric surgery Date: ____/____/________
- ☐ Tonsillectomy Date: ____/____/________
- ☐ Sinus surgery Date: ____/____/________
- ☐ Sleep apnea surgery Date: ____/____/________
- ☐ Other________________________________ Date: ____/____/________

THE EPWORTH 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 some of these things recently, try to work out how they would have affected you. **Use the following scale to circle the most appropriate number for each situation.**

Scale	Chance of dozing				Circumstance
0 = Would never doze	0	1	2	3	Sitting and reading
1 = Slight chance of dozing	0	1	2	3	Watching television
2 = Moderate chance of dozing	0	1	2	3	Sitting, inactive in a public place (ie: theater or a meeting)
3 = High chance of dozing	0	1	2	3	As a passenger in a car for an hour without a break
	0	1	2	3	Lying down to rest in the afternoon when circumstances permit
	0	1	2	3	Sitting and talking to someone
Total score:______________	0	1	2	3	Sitting quietly after a lunch without alcohol
	0	1	2	3	In a car, while stopped for a few minutes in traffic

ABOUT LAST NIGHT (BEFORE YOUR SLEEP STUDY)

What time did you go to bed last night? ____________________ AM PM (circle one)

How long did it take you to fall asleep? ____________________

What time did you wake up today? ____________________ AM PM (circle one)

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During the day today, did you:

Take any naps? ☐ No ☐ Yes

What time(s) and how long? ______

Drink any caffeinated beverages? (coffee, tea, soda, energy drinks) ☐ No ☐ Yes

What, how much, and what time(s)? ______

Drink any alcoholic beverages? ☐ No ☐ Yes

What, how much, and what time(s)? ______

Take any medication? ☐ No ☐ Yes

What, how much, and what time(s)? ______

______

AFTER YOUR SLEEP STUDY

How long did it take you to fall asleep last night? ______

Did you wake up during the study? ☐ No ☐ Yes

If YES, how many times did you wake? ______

What awakened you? ______

How long altogether were you awake during the night? ______

How many hours of sleep do you feel you've obtained? ______

How well did you sleep here compared to home? ______

Do you feel refreshed this morning? ☐ No ☐ Somewhat ☐ Yes

Comments: ______

______

POST-TREATMENT QUESTIONS

Rate your overall difficulty using CPAP last night ☐ None ☐ Minor ☐ Moderate ☐ Extreme

Was it difficult sleeping with CPAP? ☐ No ☐ Yes

Was the CPAP mask comfortable? ☐ No ☐ Yes

Was the pressure comfortable? ☐ No ☐ Yes

Did you have nasal congestion last night? ☐ No ☐ Yes

If yes, did this cause difficulty using CPAP? ☐ No ☐ Yes

Do you feel refreshed this morning after using CPAP compared to your usual night without CPAP?

☐ No ☐ Somewhat ☐ Yes

Comments: ______

______