Prana Health
Ad Vitam - For Life

SLEEP QUESTIONNAIRE-ADULT

Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

CHIEF COMPLAINT

☐Diagnosis and treatment of sleep apnea ☐Difficulty tolerating CPAP

☐Difficulty staying awake during the day ☐Difficulty sleeping at night

☐Abnormal behaviors during sleep ☐Other (Please describe):_____

HISTORY

How long have you had a sleep problem? _____

Have you had a prior sleep study? ☐ No ☐ Yes When? _____ Where? _____

Have you had any treatments for sleep apnea? ☐No ☐Yes

Do you work shifts? ☐No ☐Yes

NIGHT-TIME SYMPTOMS

Do you snore? ☐No ☐Yes If yes, is it: ☐Mild ☐Moderate ☐Loud ☐Very Loud

How often do you snore? ☐Every night ☐Usually ☐Sometimes

Has anyone told you that you stop breathing while asleep? ☐No ☐Yes

Do you sometimes wake up gasping for breath or choking? ☐No ☐Yes

Do you have leg jerking during sleep? ☐No ☐Yes

Do you wake up in the middle of the night? ☐No ☐Yes

Do you have nasal congestion/allergies ☐No ☐Yes

Check all those that apply:

☐Strong urge to move legs prior to sleep ☐Uncomfortable sensations in your legs prior to bedtime relieved by moving ☐Vivid dreams/images just as you are falling asleep or waking up from sleep

☐Unusual behavior during sleep ☐Teeth grinding ☐Mouth breathing

DAY-TIME SYMPTOMS

How do you feel when you get up in the morning?

□Rested □Tired □Sleepy □Exhausted

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Check all those that apply:

☐Wake up with a headache ☐Wake up with a dry mouth

Check all those that apply:

☐Trouble at school or work because of sleepiness ☐Trouble staying awake while driving

☐Feeling weak (knees buckle) when emotional (angry, surprise, or laughing)

Are you suffering from problems with ☐Memory ☐Concentration ☐Solving problems

☐ Decision making ☐ Loss of Sex Drive ☐ Decreased Hearing

SLEEP PATTERN

What is your usual bedtime? _____ What time do you usually get up? _____

Activities prior to falling asleep (check all those that apply):

☐Watching TV from the bed ☐Computer activity in bed ☐Drink alcohol ☐Drink caffeinated beverages ☐Smoke ☐Read books ☐Play games in bed ☐Strenuous exercise ☐Medications (prescription or over the counter) to help you fall asleep

On average, how long does it take for you to fall asleep? _____

On average, how many times you wake up at night? _____

How many naps do you take during the day? _____

EPWORTH SLEEPINESS SCALE

How likely are you to DOZE OFF or FALL ASLEEP in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times (within the last 6 months or last year).

0 = Would NEVER doze
1= SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	**Chance of Dosing (circle one)**
Sitting and reading……..	0 1 2 3
Sitting, inactive in a public place……	0 1 2 3
Watching television……	0 1 2 3
As a passenger in a car without a break……..	0 1 2 3
Lying down in the afternoon when circumstances permit……..	0 1 2 3
Sitting and talking to someone……	0 1 2 3
Sitting after lunch without alcohol……..	0 1 2 3
In a car, while stopped for a few minutes in traffic……	0 1 2 3

TOTAL _____

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PAST MEDICAL HISTORY

Medical illness: ☐Hypertension (high blood pressure) ☐Heart attack/Angina ☐Heart Failure ☐Head Injury ☐Diabetes ☐ Nasal Congestion/discharge/bleeding ☐ Nasal blockage ☐ Facial Pain/fullness/pressure ☐ Loss of sense of smell ☐Depression ☐Stroke ☐Arrhythmia ☐Atrial Fibrillation ☐COPD ☐Allergic rhinitis ☐Seizures ☐Iron Deficiency ☐Hypothyroidism ☐Acid reflux (GERD) ☐Dentures ☐Headache ☐TM joint pain ☐Erectile dysfunction

SURGICAL HISTORY:

☐Adeno-tonsillectomy ☐UPPP ☐Appendectomy ☐Gallbladder removal ☐Hysterectomy ☐Heart Bypass ☐Stent placement ☐Cataract surgery ☐Hernia repair ☐Knee replacement ☐Hip replacement ☐Pacemaker implantation ☐C-section ☐Knee surgery ☐Breast surgery ☐Back surgery ☐Sinus surgery

FAMILY HISTORY: Does anyone in your family have or has ever had any of the following (Please check all that apply): ☐Sleep apnea ☐Loud snoring ☐Restless Leg Syndrome (RLS) ☐Narcolepsy ☐Any other major illnesses in your parents or siblings that is not listed, (please describe): _____

SOCIAL HISTORY

OCCUPATION:_____MARITAL STATUS:_____

Are you a current or former smoker? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes If yes, how much?_____

Do you drink caffeinated beverages? ☐No ☐Yes If yes, how much?_____

MEDICATION HISTORY

Have you ever been treated with sleeping medications in the past? If yes, please list them:

Drug	Dosage	Reason prescribed	Reason discontinued (Side effects or others)

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List all medications that you are currently taking, including non prescription drugs:

Drug	**Dosage**	**Times per day**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list all, if any allergies with the type of reaction:

_____ _____ _____

_____ _____ _____

_____ _____ _____

IF YOU ARE USING CPAP or BiPAP device please answer the following questions

Date treatment initiated:_____

Current CPAP/BiPAP Settings:_____cm; Any supplemental O2 _____

DME Provider: Apria, JC Home, Fletcher's JayHome, American Home, other__ _____

Mask Type: Nose, Full face, nasal prongs,

Manufacturer:_____ Model:_____ Size:_____

Previous masks tried and failed: Heated Humidity: ☐Yes ☐No

Are you having difficulty using the CPAP? If yes : ☐ mask leaks ☐ excessive dryness □ too much pressure ☐pressure sores over the nasal bridge ☐ too little pressure ☐ Air swallowing □ General discomfort ☐ Claustrophobia ☐ Discomfort in the nostrils ☐ Difficulty exhaling □

Its just not "cool" ☐ I don't want to use it ☐I am not benefiting from it ☐Other reasons

_____

_____

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REVIEW OF SYSTEMS: (Please check all that apply to you):

General: ☐Weight Loss ☐Weight Gain ☐Night Sweats

Eyes: ☐ Decreased vision ☐Glaucoma ☐ Wears Glasses

Cardiovascular: ☐Chest pain ☐Palpitation/ irregular heart beat ☐Murmur ☐Leg Swelling

Respiratory: ☐Chronic Cough ☐Shortness of breath ☐Wheezing/Asthma

Gastrointestinal: ☐Constipation ☐Hepatitis ☐Blood in the stools (ulcers, polyps, etc)

Genitourinary: ☐Bedwetting ☐Frequent urination at night ☐Decreased Libido

Musculoskeletal: ☐ Joint Pains ☐ Gout

Skin: ☐ Easily bruised ☐ Rash

Neurological: ☐Weakness ☐ Numbness and Tingling ☐ Frequent headaches ☐Neuropathy

Psychiatric: ☐Anxiety ☐Depression

Endocrine: ☐Thyroid disease ☐ Diabetes ☐ Low Testosterone

Hematopoietic: ☐Anemia (low blood count) ☐ Bleeding tendency

Ears: ☐Decreased hearing ☐Ear Infections ☐Ringing in the ears

Allergic Immunologic: ☐Seasonal allergies ☐Contact dermatitis with Neoprene ☐ Rash with electrode gel

WOMEN: ☐Irregular periods ☐Pregnant ☐Using contraceptives (some medications used in treating sleep disorders can impair the effectiveness of certain contraceptives)

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DEPRESSION SCREEN

1. **Over the *last 2 weeks,* how often have you been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ADD COLUMNS: _____ + _____ + _____ + _____

TOTAL: _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	_____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____
Somewhat difficult_____
Very difficult_____
Extremely difficult_____