TMPN – Pulmonary and Sleep

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SLEEP & HEALTH QUESTIONNAIRE

Name: _____ Date:_____

Height:_____Weight:_____DOB:_____Age:_____

Referring Physician: _____

My main sleep complaint(s) are:_____

_____

I have had this problem(s) since: _____

It is: _____ getting worse _____ staying the same _____fluctuates

List all medication and dosages:

1._____
2._____
3._____
4._____
5._____
6. _____

Social History: (circle one) Single Married Separated Divorced Widowed

Alcohol: (check one)

_____ Never
_____ Rarely (1-2 drinks per week)
_____ Moderately (3-10 drinks per week)
_____ More than 10 drinks per week
_____ Have or had problems with alcohol

Tobacco: (check one)

_____ I do **NOT** smoke
_____ I smoke cigarettes _____ packs/day
_____ I use to smoke for _____ years, but quit _____ years ago

Caffeine: cups per day I drink _____ coffee _____tea _____ cola_____ None_____

Adult operation, diseases, injuries (include dates):

1._____2._____

3._____4._____

Do you have high blood pressure? Yes _____ No _____
Have you had tonsils or adenoids removed? Yes_____ No _____

My other important sleep complaints are: (check all that apply)

_____ I have trouble sleeping at night.
_____ I can sleep all day
_____ I snore
_____ I have unwanted behaviors when I am asleep.

Explain: _____
_____

SLEEP SCHEDULE: (answer all questions)

On weekdays/workdays I usually go to bed at ……..._____

On weekdays/workdays the earliest time in the last 2 weeks I've gone to bed _____

And the latest time was at …… _____

In the evening I usually start feeling sleepy at …….. .._____

The amount of time it usually takes to fall asleep is …….. ..._____

On weekdays I wake up at ……..…...._____

My usual weekend/days off bedtime is at …….. …...._____

On weekends I wake up at …….. _____

To feel my best I need _____ hours of sleep.

The number of times at night that I wake up are …….. ... _____

The clock times that I wake up during the night are …… _____

The amount of time it takes me to go back to sleep is …… ….._____

The amount of time I am awake during the night after falling asleep is …….. _____
I urinate _____ times per night.

I wake up in the morning: _____ naturally _____by alarm.

I take a nap _____ times per week.

After a nap I feel : _____ refreshed _____ sleepy/groggy.

I usually exercise at _____ o'clock for _____ minutes.

What is your job? _____

I USUALLY WORK: (check the choices that are true for you)

_____ day shift from _____ to _____o'clock.

_____ evening shift from _____ to _____o'clock.

_____ night shift from _____ to _____ o'clock.

_____ I rotate shifts every _____ days.

Comments: _____

_____

Commuting to and from work takes _____minutes.

____ I sometimes fly across time zones.

How often? _____ How many time zones?_____

WHAT MY SLEEP IS LIKE: (check the choices that are true for you)

_____ I have been told that I snore very loudly.

_____ Sometimes a person cannot sleep in the same room, because of my snoring.

_____ I have been told that I stop breathing when I sleep.

_____ I have been told that I gasp or snort when I sleep.

_____ I sweat a lot when I sleep.

_____ My bed covers are very messed up in the morning.
_____ I am a very restless sleeper.

_____ I sometimes awaken with a sour taste in my mouth.

_____ I sometimes get heartburn at night.

MY USUAL SLEEPING POSITION: (check the choices that are true for you)

_____ On my back
_____ On my side
_____ On my stomach

_____ No single position is usual
_____ I feel that the quality of my sleep is unsatisfactory.
_____ I have been told that my legs twitch or jerk when I sleep.
_____ I have been told that I make rolling or rocking movements when I sleep.
_____ I have been told that I kick or poke my bed partner while I am sleeping.

DURING THE FIRST 30 MINUTES AFTER WAKING UP IN THE MORNING I USUALLY FEEL :

_____ Very groggy
_____ Somewhat drowsy
_____ Slightly drowsy, but awake
_____ Alert

AS AN ADULT:

_____ My dreams often wake me.

_____ I often have frightening dreams.

_____ I have wet my bed.

_____ I have been told that I bang or twist my head at night.

_____ I have hallucinations or dream like images when I am not actually asleep, but while falling asleep or waking up.

_____ I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness.

_____ I have had the sensation of a sudden weakness in my legs while awake (This may occur particularly in emotional situations.)

INSOMNIA: (check the choices that are true for you)

_____ I have trouble falling asleep at night.

_____ When I wake up during the night, I have trouble going back to sleep.

_____ Some nights, I never get to sleep, no matter how hard I try.

_____ When I try to fall asleep I worry about whether or not I can go to sleep.

_____ At night when I go to bed, I do not feel sleepy.

_____ I often sleep better in an unfamiliar bedroom, such as a hotel.

_____ When I wake up at night, I often watch the clock.

_____ I wake up in the morning long before I have to.

_____ Pain often wakes me up and keeps me from going back to sleep.
Location of pain: _____

_____ I often take sleeping pills in order to sleep.

_____ I have a creeping, crawling sensation in my legs when I lie down to sleep.

_____ Sensations in my legs keep me from falling asleep.

_____ I am a very light sleeper, I awaken easily with noises.

_____ My sleep is disturbed because of my bed partner.

_____ Generally I get up in the middle of the night for a snack.

_____ I have been depressed in the past.

_____ I have had nervous breakdowns in the past.

_____ I tend to be sad or depressed in the winter.

_____ I am a "night person".

_____ I am a "morning person".

DAYTIME SLEEPINESS: (check the choices that are true for you)

_____ I have sometimes fallen asleep at very inappropriate times such as, in meetings.

_____ I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.

_____ Usually I find myself falling asleep during half-hour TV shows.

_____ I am frequently so sleepy during the day that my work is poor.

_____ I generally feel most tired/sleepy in the afternoon.

_____ I often would like to take an afternoon nap even when I cannot.

_____ I have "come to" and suddenly became alert and found myself doing things without being aware of having started them or how I got there.

_____ I generally feel tired/sleepy all day.

_____ I function best in the morning.

_____ I function best in the evening.

_____ When I have no plans or appointments the next day, I frequently go to bed late.

_____ I frequently do not feel sleepy at bedtime and stay up until it is so late, that as a consequence, I get too little sleep.

_____ When I get a good night's sleep, I feel better the next day.

_____ Several times recently I got up later than planned, even though I went to bed at the right time.

_____ I would feel better if I slept at least one more hour every night.

_____ I like to sleep in the morning when I can.

_____ I feel that I sleep too little.

SLEEP HISTORY: (check the choices that are true for you, if possible ask your parents, or relatives to help you remember your childhood behavior)

_____ I sometimes wet the bed after the age of 6.

_____ As a child I sleepwalked.

_____ As a child I screamed in my sleep.

_____ Had frequent nightmares.

_____ I would grind my teeth in my sleep.

_____ I banged my head on the bed to sleep.

_____ My current sleep problems started in childhood.

_____ I used to fall asleep in school as a child/adolescent.

_____ I always had to fight the urge to sleep during my classes at school, when I was a child/adolescent.

_____ As a child I used to stay up late in the evening.

_____ I was told that I snored while sleeping.

_____ I was considered a hyperactive or hyperkinetic child or teenager.

FAMILY HISTORY: These questions apply to your extended family, such as parents Children, aunts, uncles etc. Relatives that are related by blood.

_____ A relative died from crib death or sudden infant death.

_____ Family that have been or are hyperactive or hyperkinetic as children.

TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Sleep Disorders Center

Sleep Questionnaire

Name_____ Date: ____ / ____ / ____
DD MM YY

Date of Birth: ____ / ____ / ____
DD MM YYYY

You may be asked to complete this questionnaire each time you visit. We would like to understand to what extent your sleep apnea and/or snoring is impacting your daily activities, emotions, and social interactions. It is very important to measure this prior to starting any treatment and then again at various intervals after treatment has begun. **Please indicate the numeric value that best answers the question to each situation described.**

Sleep Apnea Quality of Life Questionnaire (SAQLI)

SITUATIONS	#
1. How much have you had to push yourself to remain alert during a typical day? (e.g. work, school, childcare, housework)	
2. How often have you had to use all your energy to accomplish your most important activity? (e.g. work, school, childcare, housework)	
3. How much difficulty have you had finding the energy to do other activities? (e.g. exercise, relaxing activities)	
4. How much difficulty have you had fighting to stay awake?	
5. How much of a problem has it been to be told that your snoring is irritating?	
6. How much of a problem have frequent conflicts or arguments been?	
7. How often have you looked for excuses for being tired?	
8. How often have you not wanted to do things with your family and/or friends?	
9. How often have you felt depressed, down, or hopeless?	
10. How often have you been impatient?	
11. How much of a problem has it been to cope with everyday issues?	
12. How much of a problem have you had with decreased energy?	
13. How much of a problem have you had with fatigue?	
14. How much of a problem have you had waking up feeling unrefreshed?	

RESPONSE	#
Not at all	**7**
A small amount	**6**
A small to moderate amount	**5**
A moderate amount	**4**
A moderate to large amount	**3**
A large amount	**2**
A very large amount	**1**

Sleepiness Assessment (Epworth Sleepiness Scale)

How likely are you to doze off or fall asleep in the following situations? **Please indicate the numeric value that best answers the question**

SITUATIONS	#
1. Sitting and reading	
2. Watching television	
3. Sitting inactive in a public place (e.g. a theatre or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. In a car while stopped for a few minutes in traffic	

RESPONSE	#
No chance of dozing	**0**
Slight chance of dozing	**1**
Moderate chance of dozing	**2**
High chance of dozing	**3**