St. Charles Hospital
Catholic Health Services
At the heart of health

ACCREDITED MEMBER CENTER

ST CHARLES HOSPTIAL SLEEP DISORDERS CENTER
SLEEP QUESTIONNAIRE

Patient Name: _____Date of Birth: _____SS#_____

Address: _____ ☐ Male ☐ Female

_____

Email address _____

Home Telephone #: ( )_____ Cell Phone: # ( )_____

HOW DID YOU HEAR ABOUT US?

Referred by Dr. _____ Friend or Family Member: _____

Advertisement: _____Website:_____ Other:_____

EMPLOYER:

Employer Name: _____

Address: _____

Telephone #:_____

Occupation: _____ Usual Work Hours/Days: _____

EMERGENCY CONTACT PERSON:

NAME_____ TELEPHONE # ( )_____

Address: _____

Relationship to Patient: _____

PHYSICIANS:

Referring Physician: _____

Address: _____

Telephone #:_____ FAX #_____

Primary Care Physician: _____

Address: _____

Telephone #_____ FAX #_____

PRIMARY MEDICAL INSURANCE:

Insurance Company:_____

Telephone # (On back of card) _____

ID #_____ Group #_____

Plan#: _____

Policy Holder's Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

POLICY HOLDER'S EMPLOYER:

Employer Name:_____

Address:_____

Telephone #:_____

SECONDARY MEDICAL INSURANCE:

Insurance Company:_____

Telephone # (On back of card) _____

ID #_____ Group #_____

Plan#: _____

Policy Holder's Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

POLICY HOLDER'S EMPLOYER:

Employer Name:_____

Address:_____

Telephone #:_____

ELECTRONIC SCRIPT INFORMATION (AS REQUIRED BY NYS):

Pharmacy name:_____

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Pharmacy address:_____

Pharmacy telephone#:_____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

Do you current own a CPAP or BPAP unit? ☐ Yes ☐ No

If yes, what is the name and number of the company you received your CPAP/BPAP equipment from?

Name/Number: _____

My Main Sleep Complaint(s) Is:

- ❑ Trouble sleeping at night For how many months/years? _____
- ❑ Being sleepy all day For how many months/years? _____
- ❑ Snoring For how many months/years? _____
- ❑ Unwanted behaviors during sleep, explain _____
- ❑ Other, explain _____

Present &Past Medical History:

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems

- ❑ Cancer
- ❑ Erectile dysfunction/impotence
- ❑ Thyroid problems

List other past medical history and dates:

_____ _____

_____ _____

Past Sleep Evaluation and Treatment:

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

List Surgeries:

Tonsillectomy Yes No

_____ _____

_____ _____

Family History:

Has an immediate blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation
❑	❑	Cancer	_____	❑	❑	Stroke	_____
❑	❑	Diabetes	_____	❑	❑	Anxiety/Depression	_____
❑	❑	Hypertension	_____	❑	❑	Sleep Apnea _____	

❑ ❑ Heart disease _____ ❑ ❑ Narcolepsy _____

❑ ❑ Thyroid disease _____ ❑ ❑ Other: _____

Social History:

Do you smoke? ❑ Yes ❑ No

If Yes:	What?	Amount per Day	For How Many Years
	❑Cigarettes	_____ pack(s)	_____ years
	❑Cigars	_____ cigars	_____ years
	❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes:	What?	Frequency			Amount per Week
	❑Beer	❑Daily	❑Weekends	❑Rare	_____ cans/week
	❑Wine	❑Daily	❑Weekends	❑Rare	_____ glasses/week
	❑Liquor	❑Daily	❑Weekends	❑Rare	_____ shots/week

❑ Sleep alone
❑ Share a bed with someone
❑ Share a bedroom, but have separate beds
❑ Share a dwelling, but have separate bedrooms

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employment Status: ❑Employed ❑Unemployed ❑Retired

❑ My job requires driving a vehicle
❑ I work with dangerous equipment or substances
❑ I am a shift worker on rotating shifts
❑ I am a permanent or long-term, third-shift worker
❑ I am currently a student

Vital Statistics:

What is your: **Height?** ____ feet _____inches **Weight?** _____ pounds Neck Size: _____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Current Medications:

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day

_____ _____

Allergies (latex, meds etc): _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each of the situations listed below:

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 television	_____
Sitting, inactive in a public place (e.g., in a theater or in 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 traffic	_____

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BED PARTNER QUESTIONNAIRE

Check any of the following behaviors that you have observed the patient doing **while asleep**:

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

Sleep Pattern

	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____ a.m./p.m.

	Work Days (Weekday)	Off Days (Weekends)
How do you usually awaken, i.e., alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____ a.m./p.m.
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

Please check all of the following statements that are true about your sleep

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs

- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Using the Answer Key below, please circle the number that best applies to your life over the past 6 months.

Answer Key **1** – Never (Strongly disagree) **2**- Rarely (Disagree) **3** – Sometimes (Not sure) **4** – Usually (Agree) **5** – Always (Agree strongly)

I have trouble falling asleep	1	2	3	4	5
I wake up often during the night	1	2	3	4	5
At bedtime, thoughts race through my mind	1	2	3	4	5
At bedtime, I feel sad and depressed	1	2	3	4	5
When falling asleep, I feel paralyzed (unable to move)	1	2	3	4	5
When falling asleep, I have restless legs (creepy-crawly feelings, aching, or inability to keep legs still)	1	2	3	4	5

If I wake up during the night, I have trouble getting back to sleep because of restless legs or leg movements	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breathe	1	2	3	4	5

Answer Key **1** – Never (Strongly disagree) **2**- Rarely (Disagree) **3** – Sometimes (Not sure) **4** – Usually (Agree) **5** – Always (Agree strongly)

At night my heart pounds, beats rapidly, or beats irregularly	1	2	3	4	5
I sweat a great deal at night	1	2	3	4	5
My sleep is disturbed by sadness or depression	1	2	3	4	5
I have a lot of nightmares (frightening dreams)	1	2	3	4	5
I feel unable to move (paralyzed) after a nap	1	2	3	4	5
I have dream-like images (hallucinations) as I wake up in the morning, even though I know I am not asleep	1	2	3	4	5
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	1	2	3	4	5
I have been unable to sleep at all for several days	1	2	3	4	5
I feel that I have insomnia	1	2	3	4	5
I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
I got bad grades in school because I was too sleepy	1	2	3	4	5
In the past 6 months I have fallen asleep while eating, talking to someone, riding in a bus or car, reading a book, watching TV or a movie, or listening to a lecture	1	2	3	4	5
I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
I often have to let someone else drive the car because I am too sleepy to drive	1	2	3	4	5
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	1	2	3	4	5

I often am unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it	1	2	3	4	5
I get "weak knees" when I laugh	1	2	3	4	5
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations ofstrong emotion	1	2	3	4	5
I have high blood pressure (or once had it)	1	2	3	4	5
I am unhappy about loving relationships in my life	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
I smoke tobacco within two hours before bedtime	1	2	3	4	5
I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	1	2	3	4	5
My snoring or my breathing problem is much worse if I sleep on my back	1	2	3	4	5
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	1	2	3	4	5

How long have you been aware of the sleep behavior(s) that you checked above?

_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

_____

_____

_____

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

Check any of the following symptoms you have had in the past 12 months:

Yes	No		Yes	No	
❑	❑	Morning headaches	❑	❑	Frequent heartburn / indigestion
❑	❑	Fainting or passing out	❑	❑	Abdominal pain
❑	❑	Sudden loss of vision or strength	❑	❑	Inability to speak
❑	❑	Dry mouth	❑	❑	Irritability
❑	❑	Decreased libido	❑	❑	Frequent constipation
❑	❑	Decreased concentration	❑	❑	Frequent diarrhea
❑	❑	Memory loss	❑	❑	Rectal bleeding / black stools
❑	❑	Hearing loss or ringing in ear(s)			
❑	❑	Hoarseness for more than 2-4 weeks	❑	❑	Difficulty urinating / incontinence
❑	❑	Nosebleeds	❑	❑	Blood in urine
❑	❑	Cough for more than 2-4 weeks	❑	❑	Urinating more than 2 times per night
❑	❑	Coughing up blood	❑	❑	Pain in joints or bones
❑	❑	Shortness of breath or wheezing	❑	❑	Unusual bruising or bleeding
❑	❑	Swelling in feet or ankles	❑	❑	Epilepsy / seizures
❑	❑	Chest pain, tightness or pressure	❑	❑	Change in wart, mole or skin growth
❑	❑	Irregular or sudden, fast heartbeat	❑	❑	Weight loss of more than 5-10 lbs.
❑	❑	Difficulty swallowing or food "sticking"			