Pulmonary Associates of St. Augustine

Sleep Confidential Questionnaire

Your physician has requested that you have a consultation with a Sleep Specialist. Prior to that consultation, we request that you complete this questionnaire. It asks questions not only about your sleeping habitsbut also regarding other breathing problems. Answer these questions to the best of your ability.If you find questions that you cannot answer, mark them with a question mark. If possible, have someone familiar with your sleeping habits help you fill out this questionnaire and bring that person along with you to the consultation. It is quite helpful for the physician to interview someone who has observed you sleeping.

GENERAL INFORMATION:

What is your primary problem with sleep?_____

_____

How long have you had the sleep problem? _____months _____years

SLEEP SCHEDULE AND SLEEP HYGIENE: (Circle ALL that apply)

	Weekend/Holiday	Weekdays/Workdays
What time do you usually **go to bed**?	_____	_____
What time do you usually **get up**?	_____	_____
How may hours do you usually sleep?	_____	_____

Do you take **daytime naps**? Y/N
Are you usually **refreshed** by a night's sleep? Y/N
Do you keep a fairly **regular** sleep/wake schedule? Y/N
Do you do any of the following in **bed**? (Circle all appropriate): Read Watch TV Write Eat Worry
Do you currently do shift work? Y/N
Have you done shift work in the past? Y/N
Do you have trouble sleeping when you are doing shift work? Y/N
If you could set your own schedule, what time would you go to bed? _____:_____ __a.m. __p.m.
What time would you get up? _____:_____ __a.m. __p.m.

INSOMNIA: (Circle ALL that apply)

Based on your experience in the last six months answer the following questions, with "night" meaning your major sleeping time.

Do you often have trouble falling to sleep? Y/N
What is the average number of minutes it takes you to fall asleep at night?_____minutes
Do you often have awakenings during the night? Y/N If yes, average number of times per night?____
Do you have long periods when you awaken and are not able to get back to sleep? Y/N
Are you bothered by waking up too early and not being able to get back to sleep? Y/N
How many nights a week do you feel you have a sleep problem? _____nights per week
Is your sleep disrupted by your bed partner? Y/N ___Snoring ___Movement

PARASOMNIAS: (Circle ALL that apply)

Did you have a sleep problem as a child? Y/N If yes, describe:_____
Do you currently have nightmares or night terrors? Y/N How frequent?_____
Do you grind or clench your teeth at night? Y/N Have you ever been told you act out dreams? Y/N
Did you frequently wet the bed as a child? Y/N Have you recently walked in your sleep? Y/N
Have you ever been told that you walk in your sleep? Y/N

MOVEMENT: (Circle ALL that apply)

Answer the following questions based on the most recent six months.

Has your bed partner ever complained of your legs kicking during the night? Y/N
Do you have restless sense of discomfort (crawling sensation) in your legs during the waking hours? Y/N
Do you exercise regularly? Y/N

Patient's Name_____ Date_____

EXCESSIVE SLEEPINESS: (Circle ALL that apply)
Do you feel excessively sleepy in the daytime? Y/N If yes, how long:___months/years (circle one)
Have you ever had an accident or near-miss accident because of falling asleep driving? Y/N
If yes, describe:_____
Have you ever felt sudden muscle weakness when you laughed, got angry, or were surprised? Y/N
Have you ever been unable to move your body just as you were falling asleep or waking up? Y/N
Do you have difficulty distinguishing your dreams from reality? Y/N
If yes, describe:_____
How often do you wake with morning headaches? __Never __Monthly __Weekly __Daily
How often do you wake up with a dry mouth or sore throat?__Never __Monthly __Weekly __Daily
Have you been told that you stop breathing during sleep? __Some nights __Every night __No
Have you awoken with a snort, choking sensation, or shortness of breath? __Some nights __Every night __No
How often do you snore? __Never __Occasionally ___Nightly
How loud is your snoring? __Not Very __Somewhat __Very __Don't know
In which position(s) do you prefer to sleep? __Back __Right Side __Left Side __Stomach __Other
Does sleep position affect your snoring? __N/A Y/N
Do you have difficulty breathing through your nose? Y/N If yes, describe:_____
Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)? Y/N
If yes, describe:_____
Do you have heartburn, gastric acid reflux, or a hiatal hernia? Y/N
Do you use oxygen or any type of medical equipment when you sleep? Y/N
If yes, describe:_____
Have you have gained weight? Y/N Have you attempted to diet? ___N/A Y/N

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. 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 fo each situation:
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 TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score:	_____

Additional comments regarding your sleep:_____
_____

RESPIRATORY SYMPTOMS: FILL OUT IF APPLICABLE. (Circle ALL that apply)
Do you have any of the following complaints?
1. Shortness of Breath: Y/N, how long?_____ 2. Are you short of breath resting? Y/N
3. How much can you walk before getting short of breath? Block?_____ Room to Room?_____
4. What triggers your shortness of breath? trees Y/N cats Y/N birds Y/N activity Y/N wind Y/N heat Y/N humidity Y/N cold air Y/N pollen Y/N ragweed Y/N other _____
5. Any breathing problems as a child, teenager, or adult? _____
6. Have you ever taken any medications(tablets or inhalers) for breathing problems? If yes, please list: _____
7. Do you have a home nebulizer? Y/N 8. Are you on Home oxygen? Y/N, how long?_____
9. How many pillows do you use under your head when sleeping? _____
10. Do you wake up at night short of breath? Y/N or choking? Y/N
11. Do you have swelling in your feet or ankles? Y/N
12. Cough? Y/N, how long?_____ Dry/Productive, color of phlegm (sputum) _____
13. Have you ever coughed up blood or streaks of blood? Y/N, when?_____
14. Have you ever had: Wheezing? Y/N Chest Pains? Y/N Heartburn? Y/N Choking on food? Y/N Runny Nose? Y/N Post Nasal Drip? Y/N Frequent throat clearing? Y/N Nosebleeds? Y/N Weight Loss? Y/N Weight Gain? Y/N Skin Rash?_____

Patient's Name_____

FAMILY HISTORY: (In true blood relation) (Circle ALL that apply)

(Problems: Asthma, COPD, Emphysema, Cystic Fibrosis, End-stage Cancer, D.V.T., P.E., Sleep Apnea)
Mother: Problem_____ Living/Deceased
Father: Problem_____ Living/Deceased
True Brother and Sister: Problem _____
Children: Y/N, Problem _____
Do other members of your immediate family experience restless legs? Y/N
Do other members of your immediate family have any other problems with sleep? Y/N

SOCIAL HISTORY: (Circle ALL that apply)
Have you ever smoked cigarettes, cigar, or a pipe? Y/N Do you currently smoke cigarettes? Y/N
If yes, estimate the average packs of cigarettes per day while you were smoking:_____
Years of cigarette smoking:_____If you quit smoking, when did you quit?_____
Please indicate the number of cups per day consumed of caffeinated beverages: _____
Do you currently smoke marijuana or take any other mood-altering illicit drugs? Y/N
If yes, what and how often:_____
Did you ever drink alcohol? Y/N Do you currently drink alcohol? Y/N Amount?_____

PAST MEDICAL HISTORY: (Circle ALL that apply)
Have you ever been diagnosed with:
1. Asthma? Y/N How long?_____
2. Emphysema? Y/N How long?_____
3. COPD? Y/N How long?_____
4. Chronic Bronchitis? Y/N
5. Pneumonia? Y/N How long?_____
Did it require hospitalization? Y/N
6. Tuberculosis (TB)? Y/N
Did you ever have a positive TB skin test? Y/N
7. Bronchiectasis? Y/N
8. Blood clot in legs? Y/N
9. Do you have Hypertension? Y/N
10. Stomach ulcer? Y/N
11. Diabetes Mellitus? Y/N
12. Heart attack? Y/N
13. Congestive Heart Failure? Y/N
14. Lung Cancer? Y/N
What treatment was given?_____
15. Do you take Coumadin? Y/N
16. Any other Cancer? Y/N
What treatment was given?_____
17. Other medical problems?_____
18. HIV/AIDS? Y/N

PAST SURGICAL HISTORY: (Circle ALL that apply)
1.Chest or lung surgery? Y/N
What kind?_____When?_____
2. Uterus and/or ovaries removed? Y/N
3. Tonsils removed? Y/N
4. Appendix removed? Y/N
5. Sinus surgery? Y/N
6. Gall Bladder removed? Y/N
7. Any other surgeries? Y/N, when?_____ What?_____

PSYCHOLOGICAL HISTORY: (Circle ALL that apply)
Do you feel depressed? Y/N Now? Y/N
Have you **ever** seen a psychiatrist or any other type of counselor? Y/N Currently? Y/N

OCCUPATIONAL HISTORY: (Circle ALL that apply)
What work have you done most of you life?_____
Have you had exposure to any of the following?
A. Asbestos (car brakes, pipe fitter, roofing, tiling, boiler work, ship yard work)
B. Sand/Silica dust, cement (construction work)
C. Smoke inhalation
D. Heavy metal grinding/tool and dye making
E. Farm work
F. Mustard gas, nerve gas, agent orange, lewisite, military experiments
G. Desert Storm
H. Veterinarian work

VACCINATION HISTORY: (Circle ALL that apply)
Flu Vaccine: Y/N When?_____
Pneumonia Vaccine: Y/N When?_____

Patient's Name_____

ENVIRONMENTAL HISTORY: (Circle ALL that apply)

Do you have any of the following? Cat Y/N Dogs Y/N Birds Y/N Other_____
Home air conditioning? Y/N Air Cleaner? Y/N Hepa filter? Y/N
Dusty environment at home? Y/N

TRAVEL HISTORY: (Circle ALL that apply)
Travel to the Southwest or Midwest? Y/N When?_____
Travel to far East countries? Y/N When?_____
Travel to South America/Haiti? Y/N When?_____

ALLERGIES: (Please list all allergies)
Food Allergy:_____Egg Allergy: Y/N Peanut Allergy: Y/N
Medication Allergy:_____
Environmental Allergy:_____
Have you ever seen an allergy specialist? Y/N Had allergy testing? Y/N Allergy shots? Y/N When?_____

Thank you for your cooperation in completing this questionnaire.

Patient's Name_____