# SLEEP QUESTIONNAIRE

PATIENT NAME: _______________________________________________ DATE: ________________________

Height:__________ Weight:__________ ☐ Male ☐ Female

| FOR OFFICE USE ONLY | |
|---|---|
| 703 x $\frac{weight\ (lbs)}{height^2 (in^2)}$ = BMI | BMI:<br>BMI more than 30? ☐ NO ☐ YES |
| Neck size (measuring around the adam's apple) | |
| Males: inches | 17 in./42cm or larger ☐ NO ☐ YES |
| Females: inches | 16 in./41cm or larger ☐ NO ☐ YES |

| PLEASE ANSWER NO OR YES TO THE FOLLOWING QUESTIONS: | | |
|---|---|---|
| Have you ever been diagnosed with Sleep Apnea? | ☐ NO | ☐ YES |
| Have you ever had/used a CPAP machine? | ☐ NO | ☐ YES |
| Have you ever participated in a sleep study? Date of your sleep study: | ☐ NO | ☐ YES |

| | | |
|---|---|---|
| Do you think you get enough sleep at night? How many hours: | ☐ NO | ☐ YES |
| Do you or have you been told you snore? Would you say: ☐ MILD ☐ MODERATE ☐ SEVERE | ☐ NO | ☐ YES |
| Has anyone observed you stop breathing or choking/gasping during your sleep? | ☐ NO | ☐ YES |
| Have you ever awaken yourself with a snort, choking/gasping for air? | ☐ NO | ☐ YES |
| Do you have trouble falling asleep? | ☐ NO | ☐ YES |
| Do you have trouble staying asleep throughout the night? | ☐ NO | ☐ YES |
| Do you often wake in the morning with a headache? | ☐ NO | ☐ YES |
| Do you often feel tired, fatigued, or sleepy during the daytime? | ☐ NO | ☐ YES |
| Do you take naps during the day? If so, how long?_______________ | ☐ NO | ☐ YES |
| Do you awaken with acid or sour taste in your mouth? | ☐ NO | ☐ YES |
| Do you have acid reflux or wake with heartburn at night or in the morning? | ☐ NO | ☐ YES |
| Do you sometimes feel you have a lump in your throat? | ☐ NO | ☐ YES |

| | | |
|---|---|---|
| Have you ever broken your nose? | ☐ NO | ☐ YES |
| Have you ever had sinus or nasal surgery? TYPE: | ☐ NO | ☐ YES |
| Have you ever been told you have a deviated septum? | ☐ NO | ☐ YES |
| Have you had any type of head or neck injury? EXPLAIN: | ☐ NO | ☐ YES |
| Have you had your tonsils or adenoids removed? | ☐ NO | ☐ YES |

| | | |
|---|---|---|
| Do you experience restless legs, repetitive limb jerks or night sweats? | ☐ NO | ☐ YES |
| Do you have or have you been diagnosed with high blood pressure? | ☐ NO | ☐ YES |
| Do you have or have you been diagnosed with heart problems (other than high blood pressure)? | ☐ NO | ☐ YES |
| Do you have type 2 diabetes or other blood sugar problems? | ☐ NO | ☐ YES |
| Do you have to urinate several times during the night or males, have you been diagnosed with BPH? | ☐ NO | ☐ YES |
| Do you have any pulmonary conditions such as COPD, Asthma or Chronic Bronchitis? | ☐ NO | ☐ YES |
| Have you had surgery to promote weight loss? TYPE: | ☐ NO | ☐ YES |

## EPSWORTH SLEEPINESS SCALE

PLEASE INDICATE HOW LIKELY YOU ARE TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS. CIRCLE ONE RESPONSE FOR EACH QUESTION:

0 = NEVER 1 = SLIGHT 2 = MODERATE 3 = HIGH CHANCE OF DOZING OFF

| | | | | |
|---|---|---|---|---|
| SITTING AND READING | 0 | 1 | 2 | 3 |
| WATCHING TELEVISION | 0 | 1 | 2 | 3 |
| SITTING INACTIVE IN A PUBLIC PLACE (e.g. theater, meeting) | 0 | 1 | 2 | 3 |
| AS A PASSANGER IN A CAR FOR ONE HOUR WITHOUT A BREAK | 0 | 1 | 2 | 3 |
| SITTING DOWN QUIETLY AFTER LUNCH WITHOUT ALCOHOL | 0 | 1 | 2 | 3 |
| LYING DOWN TO REST IN THE AFTERNOON | 0 | 1 | 2 | 3 |
| SITTING OR TALKING TO SOMEONE | 0 | 1 | 2 | 3 |
| IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC | 0 | 1 | 2 | 3 |

MY TOTAL SCORE: _______________

PATIENT/GUARDIAN SIGNATURE:____________________________________