Sleep History Questionnaire

Patient Name: _____

Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____

Male ☐ Female ☐

Referring Physician: _____ Contact ID: _____

What are the Chief Complaints for which you are seeking treatment?

Please number your complaints with #1 being the most severe, #2 the next most severe, etc.

Number each **(#1 being the most severe)**	Frequency **(1-4)**	Intensity **(1-10)**
_____ CPAP intolerance	_____	_____
_____ Difficulty concentrating	_____	_____
_____ Excessive daytime sleepiness	_____	_____
_____ Fatigue	_____	_____
_____ Forgetfulness	_____	_____
_____ Frequent snoring	_____	_____
_____ Gasping causing waking up	_____	_____
_____ Impaired thinking	_____	_____
_____ Insomnia	_____	_____
_____ Morning headaches	_____	_____
_____ Nighttime choking spells	_____	_____
_____ Snoring which affects the sleep of others	_____	_____
_____ Witnessed cessation of breathing	_____	_____

If others, please write them down on the space below.

_____

_____

_____

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No Chance	**Slight Chance**	**Moderate Chance**	**High Chance**	
○	○	○	○	Sitting and reading
○	○	○	○	Watching T.V.
○	○	○	○	Sitting in a public place (e.g. a theater or a meeting)

Patient Signature: _____ Date: _____/_____/_____

Sleep History Questionnaire

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No Chance	Slight Chance	Moderate Chance	High Chance	
◉	○	○	○	As a passenger in a car for an hour without break
◉	○	○	○	Lying down to rest in the afternoon when circumstances permit
◉	○	○	○	Sitting and talking to someone
◉	○	○	○	Sitting quietly after lunch without alcohol
◉	○	○	○	In a car, while stopped for a few minutes in traffic

Sleep Studies

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: _____/_____/_____

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The evaluation of a diagnosis of _____

The evaluation showed:

	During REM	Supine	Side
An RDI of _____	____	____	____
An AHI of _____	____	____	____

A nadir SpO_2 of ___ T90 ___ ODI (Oxygen Desaturation Index)___

Slow wave Sleep ☐ Decrease ☐ None

REM sleep ☐ Decrease ☐ None

Additional Questions

Are you a current CPAP (Continuous Positive Air Pressure) user? ☐ Yes ☐ No

If yes, what are the current CPAP settings? _____

Patient Signature: _____ Date: _____/_____/_____

Sleep History Questionnaire

CPAP Intolerance (Continuous Positive Airway Pressure device)

☐ Mask leaks

☐ Inability to get the mask to fit properly

☐ CPAP does not seem to be effective

☐ An unconscious need to remove the CPAP

☐ Discomfort from headgear

☐ Pressure on the upper lip causing tooth related problems

☐ Does not resolve symptoms

☐ Disturbed or interrupted sleep

☐ Latex

☐ Noisy

☐ Noise disturbing sleep and/ or bad partner sleep

☐ Claustrophobic associations

☐ Cumbersome

☐ CPAP restricted movements during sleep

Other:_____

_____

_____

Other Therapy Attempts

Include:

☐ Dieting

☐ Weight Loss

☐ Surgery (Uvuloplasty)

☐ Surgery (Uvlectomy)

☐ Pillar procedure

☐ Smoking cessation

☐ CPAP

☐ BiPAP

☐ Uvulectomy (but continues to have symptoms)

☐ Uvuloplasty (but continue to have symptoms)

☐ Positional therapy (side sleeping)

☐ Nasal strip

History of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/_____

Patient Signature: _____ Date: _____/_____/_____

Sleep History Questionnaire

Sleep History

Previous Diagnosis

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? _____ ☐ Years ago ☐ Months ago ☐ Days ago

Sleep:

Sleep Onset Latency _____ minutes

Sleep Aid ☐ Yes ☐ No
If yes, name the medication _____

Normally goes to bed at ____ ☐ AM ☐ PM

Hours of sleep per night _____ hours.

☐ Buxism (grinding teeth)

☐ Dry Mouth

☐ Excessive movements

☐ Gasping

_____ Getting up (# of times per night)

☐ Restless legs

☐ Waking up and having difficulty returning to sleep

☐ Dreaming

_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

☐ Worse when sleeping on your back

☐ Worse when following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

☐ Awakens refreshed

☐ Has morning headaches

Naps _____

Snoring is reported as:

Frequency _____

Severity _____

☐ Worse following alcohol late at night

☐ Worse when sleeping on your back

Patient Signature: _____ Date: _____/_____/_____

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