Providence Medical Group

Patient Name:_____

Date of Birth:_____

Today's Date:_____

Pulmonary and Sleep Medicine

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Patient Sleep Questionnaire

Height:_____Weight Now:_____1 year ago:_____5 years ago:_____

What is your main concern about your sleep?_____

How long has this been a problem?_____weeks / months / years (circle one)

Have you ever had a sleep study? Yes / No (circle one) If so, when and where?_____

Have you ever been on ☐CPAP ☐BiPAP ☐Oxygen therapy

Are you currently on CPAP/BiPAP?_____Where do you get supplies?_____

Have you ever had other sleep-related treatment(s) such as sleep aids, etc.?_____

Sleep Schedule

When do you go to bed usually? During Workdays:_____Weekends:_____

How soon do you fall asleep?_____How many times do you wake up from sleep?_____

What seems to wake you up?_____

How long does it commonly take to fall back asleep?_____

When do you wake up in the morning?_____Do you need an alarm to wake up?_____

When do you get up in the morning?_____

Do you feel refreshed or well rested when you wake up?_____

Do you take naps?_____When?_____How Long?_____

What medications, herbs, teas, etc., do you take to help you sleep?_____

_____

_____

Sleep Environment

Do you sleep ☐ Alone ☐ With someone in the same room ☐ With someone in the same bed

Are there any changes in your sleeping arrangements because of death, divorce, illness or other reasons? Please explain:

_____

_____

Is your bedroom: Cool?_____Quiet?_____Dark?_____

Is your sleep disturbed because of your partner, others in your household or pets?_____

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- □ Have been told of snoring?
- □ Frequency of snoring? (circle one) Nightly / Occasionally / Rarely / Never / When on my back / Unknown
- □ Bed Partner observation of apnea, breath holding, gasping, mouth breathing, or labored breathing?
- □ Wake myself up gasping for air or from snoring?
- □ Awaken to use the bathroom? Frequency per night? _____
- □ Awaken with dry mouth or sore throat?
- □ Experience daytime sleepiness, tiredness, fatigue, low energy?
- □ Awaken with headaches, or frequent daytime headaches?
- □ Cannot sleep on back.
- □ Have heartburn, dyspepsia, or reflux symptoms (day or night)

- □ I have difficulty falling asleep or staying asleep.
- □ I awaken earlier in the morning than I would prefer.
- □ Thoughts race through my mind and prevent me from getting sleep.
- □ I often wake up and have trouble going back to sleep.
- □ I worry about things and have trouble relaxing.
- □ I lie awake for half an hour of more before I fall asleep.
- □ I often feel frustrated, sad or depressed because I can't sleep.
- □ I have my days and nights mixed up.

- □ I have felt drowsy while driving.
- □ I have fallen asleep while driving.
- □ I have trouble with concentration skills, alertness, vigilance, or remaining awake.
- □ I have trouble with attention span and distractibility.
- □ I have fallen asleep in social settings such as movies, at work or at a party.

- □ I have fallen asleep unexpectedly.
- □ I have fallen asleep when emotionally charged, such as laughing or arguing.
- □ I have experienced vivid dreams or hallucinations shortly after falling asleep or just after awakening.
- □ I start to dream soon after falling asleep or during naps.
- □ I have "sleep attacks" during the day no matter how hard I try to stay awake.
- □ I have had episodes of feeling paralyzed upon awakening.

- □ I have noticed or been told that I kick and jerk during sleep.
- □ I experience an aching or crawling sensation with my legs.
- □ I experience leg cramps at night.
- □ Sometimes I can't keep my legs still; I just have to move them to feel comfortable.

- □ I have troubling dreams.
- □ I have had episodes of sleepwalking or confusing awakenings.
- □ I eat or talk in my sleep.
- □ I have been told that I act out my dreams.
- □ I grind or clench my teeth during my sleep.

Dental History

- □ History of orthodontia (braces, retainers, etc.)? When:_____
- □ Most recent dental visit: (month/year):_____
- □ Dentures?
- □ Dental splint for bruxism/teeth grinding?

Surgical History

- □ Tonsillectomy, adenoidectomy, or combined adenotonsillectomy?
- □ Nasal or sinus surgery, septum repair, or rhinoplasty.
- □ Dental surgery on mandible or maxilla?

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling generally tired; considering your usual way of life in recent times? If you have not done some of these things recently, consider how they would have affected your falling asleep or dozing off.

Chance of dozing or falling asleep In the following situations:	***Please circle appropriate response***			
	Never	*Slight*	*Moderate*	*High*
Sitting and reading	*0*	*1*	*2*	*3*
Watching TV	*0*	*1*	*2*	*3*
Sitting, inactive, in a public place (e.g., a theater or meeting)	*0*	*1*	*2*	*3*
As a passenger in a car for an hour without a break	*0*	*1*	*2*	*3*
Lying down to rest in the afternoon when circumstances permit	*0*	*1*	*2*	*3*
Sitting and talking with someone	*0*	*1*	*2*	*3*
Sitting quietly after lunch without alcohol	*0*	*1*	*2*	*3*
In a car, while stopped for a few minutes in traffic	*0*	*1*	*2*	*3*

N.O.S.E. Questionnaire

Over the past ONE month, how much of a problem were the following conditions for you?	**Please circle the appropriate response**				
	Not a Problem	*Very Mild Problem*	*Moderate Problem*	*Fairly Bad Problem*	*Severe Problem*
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or Obstruction	0	1	2	3	4
Trouble breathing through my nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through my Nose during exercise or exertion	0	1	2	3	4

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Bed Partner or Helpful Observer's Questionnaire

Note to patient: This form is to be given to someone who has watched you sleep.

Where do you usually sleep in relation to the patient?

- □ Same Bed
- □ Same Room
- □ Same House

How often have you observed this person's sleep?

- □ Nightly
- □ Often
- □ Infrequently

Please check any of the following behaviors that you observed while the patient was asleep:

□ Light snoring	□ Twitching or kicking of the legs/arms	□ Eating while asleep
□ Loud snoring	□ Dream enactment	□ Talking while asleep
□ Pauses in breathing	□ Sitting up in bed not awake	□ Grind or clench teeth
□ Occasional loud snorts	□ Getting out of bed but not awake	□ Choking
□ Gasping for air		

□ Other, please describe:_____

Describe the behaviors checked above in more detail. Please include a description of the activity, approximate time during the night of when it occurs, frequency of the behavior throughout the night, and whether it occurs every night.

_____

_____

_____

_____

Has this person ever fallen asleep during normal daily activities or in a dangerous situation?_____

If yes please explain:_____

Please include other information that might be useful to the center in trying to help this patient._____

_____

_____

_____

_____

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Review of Systems

Please indicate YES or NO if you have experienced any of the following symptoms within the past year.

GENERAL:

Feeling Poorly	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Chills	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Loss(___lbs)	☐ YES	☐ NO
Weight Gain (___lbs)	☐ YES	☐ NO

EYES:

Vision Problems	☐ YES	☐ NO
Eye Pain	☐ YES	☐ NO
Blurred Vision	☐ YES	☐ NO

EARS/NOSE/THROAT:

Nose bleeds	☐ YES	☐ NO
Sore Throat	☐ YES	☐ NO
Nasal Congestion	☐ YES	☐ NO
Facial Pain	☐ YES	☐ NO
Hearing Loss	☐ YES	☐ NO

CARDIOVASCULAR:

Shortness of Breath	☐ YES	☐ NO
Leg Swelling	☐ YES	☐ NO
Chest Pain	☐ YES	☐ NO
Palpitations	☐ YES	☐ NO

RESPIRATORY:

Wheezing	☐ YES	☐ NO
Coughing up Sputum	☐ YES	☐ NO
Cough	☐ YES	☐ NO
Coughing up Blood	☐ YES	☐ NO

GASTROINTESTINAL:

Heartburn	☐ YES	☐ NO
Abdominal Pain	☐ YES	☐ NO
Nausea	☐ YES	☐ NO
Vomiting	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO
Constipation	☐ YES	☐ NO
Blood in Stool	☐ YES	☐ NO

MUSCULOSKELETAL:

Joint Pain	☐ YES	☐ NO
Muscle Cramps	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO
Joint Swelling	☐ YES	☐ NO

PSYCHIATRIC

Depressed	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO

ENDOCRINE:

Excessive Thirst	☐ YES	☐ NO
Cold Intolerance	☐ YES	☐ NO
Heat Intolerance	☐ YES	☐ NO
Night Sweats	☐ YES	☐ NO
Skin Changes	☐ YES	☐ NO
Hair Changes	☐ YES	☐ NO

SKIN:

New Rashes	☐ YES	☐ NO
Nodule	☐ YES	☐ NO
Skin Swelling	☐ YES	☐ NO

BLOOD/LYMPHATIC:

Swollen Lymph Nodes	☐ YES	☐ NO
Easy Bruising	☐ YES	☐ NO
Easy Bleeding	☐ YES	☐ NO

GENITOURINARY:

Urinary Frequency	☐ YES	☐ NO
Urinary Urgency	☐ YES	☐ NO
Pelvic Pain	☐ YES	☐ NO
Incontinence	☐ YES	☐ NO
Nocturia	☐ YES	☐ NO

ALLERGY:

Itchy Eyes	☐ YES	☐ NO
Hay Fever	☐ YES	☐ NO
Hives	☐ YES	☐ NO