COASTAL PULMONARY CARE

Sleep Consult Questionnaire

Sleep History

What time do you go to bed? _____ PM. What time do you wake up? _____ AM.

How long does it typically take you to fall asleep when you go to bed? _____

Does the time it takes to fall asleep vary significantly from night to night? Yes / No

Is your sleep schedule on weekends the same or different as during the week day? _____

Naps

Do you take naps during the day? Yes / No

Sleep Onset

Prior to the onset of sleep do you have anxiety and/or intrusive thoughts that interfere with your ability to fall asleep? Yes / No

Do you tend to worry about it the next day? Yes / No

Sleeping Partner

Do you sleep with a partner? Yes / No

Nocturnal Awakenings

How many times during the night do you wake up? _____

Do you know what the cause is when you wake-up throughout the night? Yes / No

Do you have difficulty falling back to sleep from these awakenings? Yes / No

Leg Movements

Do you have significant leg movements at least twice a week that interfere with your ability to fall asleep? Yes / No

Parasomnias

Do you have a history of sleepwalking? Yes / No

Do you have a history of sleep talking? Yes / No

Do you have any nightmares or night terrors? Yes / No

Do you have any dream enactments, seizures or seizure-like activity? Yes / No

Are you a light or restless sleeper? Yes / No

Snoring and other symptoms of sleep disordered breathing

Do you snore and does it disturb others? _____

Do you have a dry mouth when you wake-up in the morning? _____

Do you have a headache when you wake-up in the morning? _____

Has anyone observed you stop breathing while you are sleeping? _____

Do you have restless sleep with frequent arousals? Yes / No

Do you get up at night to urinate? Yes / No

Do you have difficulty with nighttime reflux? Yes / No

When did the nighttime reflux start? _____

How severe is the nighttime reflux (mild, moderate or severe)?

Have you completed a sleep study? Yes / No

Do you wake up with a dry mouth_____? or headache in the morning _____?

Have your sleep symptoms been getting worse recently? Yes / No

Has a sleep study been done? Yes / No. If so, where? _____

Neurologic Symptoms

Do you have hypnagogic or hypnopompic hallucinations, sleep onset/sleep offset paralysis or automatic behaviors? Yes / No

Recent weight gain

Have you had any weight gain in the last 5 years? Yes / No

If yes, how much weight have you gained? _____ lbs.

Have you had weight gain? _____ weight loss? _____ Fatigue? _____

Family History:

Related to any sleep disorders, such as Narcolepsy or Obstructive Sleep Apnea.

If you already have a CPAP machine, what company supplied the machine and supplies?

Check which symptoms you have:

_____ sore throat, hoarseness, mouth breathing, nasal congestion, seasonal allergies, sinus symptoms, headaches

_____Chest pain or palpitations

_____Chest wheeze/ pulmonary symptoms, such as dyspnea during exertion or cough

Gastrointestinal: No gastrointestinal symptoms such as reflux or abdominal bloating.

_____ seizures

_____ any symptoms or pain interfering with sleep.

_____ depressive symptoms or anxiety.

_____ any upper airway surgeries in the past?

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations:
0=Never 1= slight chance 2= moderate chance 3= High chance

- Sitting and reading _____
- Watching TV _____
- Sitting inactive in a public place (e.g a theater or 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 _____
- Stopped at a stop sign or at traffic _____

Total Score: _____