Onslow Medical Specialties Clinic

Lung Diseases & Sleep Disorders Clinic
Pulmonary Function Test/ CardioPulmonary Exercise Test/ Thoracic Ultrasound
Methacholine Challenge Test/ Video-Flexible Laryngoscopy/ Sleep Disorders Lab
123 Pompano Place Suite 100
Jacksonville, NC 28546
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Sleep Questionnaire

Name: _____ Today's Date_____
Home Address:_____
Home phone:_____ Work/Cell phone:_____
Date of Birth:_____ Age:____ Height: _____inches Weight: _____lbs
Race: _____ Ethnicity:_____
Occupation:_____
Referring Physician:_____ Recent Weight gain:_____

1. Please describe your sleep problem: _____
____Excessive daytime sleepiness _____Daytime fatigue _____Loud snoring
____Stop breathing while asleep _____Gagging/choking during sleep
____Difficulty falling asleep _____Difficulty staying asleep
____Leg jerking during sleep _____ Headaches upon waking in the morning
Others:_____

2. How long has this problem bothered you? _____

3. How severe is this sleep problem for you? Encircle one:
Mild moderate severe very severe

My Main Sleep Complaints:
- Trouble sleeping at night For how many months/ years?_____

- Being sleepy all day For how many months/ years?_____

- Loud snoring For how may months/ years ?_____

- Unwanted behaviors during sleep, please explain: _____
_____

4. When sitting or lying down, do you have unpleasant or creepy-crawly sensations in your legs (and sometimes in other parts of your body), tied to a strong feeling or urge to move? _____ Yes _____No

a. Do the sensations and urge to move come on during periods of rest or inactivity, and are they relieve by movements? _____Yes ____No _____Not Applicable

b. Do the sensations and urge to move bother you more in the evening and at night, rather than during the day? _____Yes _____No _____Not Applicable

c. Do you have family members who experience these same sensations and urge to move? _____Yes _____ No Not Applicable

5. Have you ever suddenly fallen? _____ Yes _____ No

6. Have you ever experienced sudden body weakness brought on by laughter, surprise or fear? _____Yes _____No If yes, please describe_____

7. Have you ever experienced waking up from sleep but unable to move or paralyzed for several minutes? _____ Yes _____No When?_____ How many times?_____

8. Have you ever experienced seeing or hearing things that were not real when you were going to sleep or just waking up? _____ Yes _____No

9. Does anyone in your family have a sleep disorder? _____ Yes _____ No. If so, who is it, and what kind of sleep disorder is it? _____

10. On average, how many alcoholic beverages do you drink on weekdays? _____drinks/day

11. On average, how many alcoholic beverages you drink on weekends? _____drinks/day.

12. Do you smoke? _____Yes _____No If so, how many cigarettes, pipes or cigars per day? _____

13. For each one of the following, please write in the average number that you drink each day:
Coffee_____cups/day
Tea _____cups/day,
Carbonated soft drinks (brands)_____ /day

14. What are your usual working hours?

Start_____AM/PM Stop_____AM/PM
Days:_____

15. Sleep Pattern:

	Work Days (Weekdays)	Off Days (Weekends)
Typical bedtime:	_____AM/ PM	_____AM/PM
Typical Amount of Time to fall asleep	_____	_____
Typical No. of Awakenings per night	_____	_____
List any activities that you normally do During nighttime awakening(s): i.e. Restroom, eat, watch TV, internet, etc	_____	_____
Typical Amount of Time to Fall back Asleep after awakening:	_____	_____
Typical Wake Up Time:	_____AM/PM	_____AM/PM
Desired Wake Up Time:	_____AM/PM	_____AM/PM
How do you usually awaken? i.e. alarm clock? Spontaneously ? Others?	_____	_____
Typical time you get out of bed:	_____AM/ PM	_____ AM/PM
Total Amount of Sleep per Night:	_____	_____
Number of Naps per day	_____	_____

16. Please check all that apply:

Sleep Habits:
____ I usually watch TV or read in bed prior to sleep.
____ I often travel across 2 or more time zones.
____ I drink alcohol prior to bedtime.
____ I smoke prior to bedtime or when awaken during the night
____ I eat snack at bedtime.
____ I eat if I wake up during the night.
____ I typically wake up from sleep to go to the bathroom.
____ I have trouble falling asleep.
____ I often wake up during the night.
____ I am unable to return to sleep easily if I wake up during the night.
____ I have thoughts that start racing through my mind when I try to fall asleep.
____ I wake up early in the morning and I am still tired but unable to return to sleep.
____ I have nightmares as an adult.
____ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.
____ I sweat a great deal during sleep.
____ I cannot sleep on my back.

Breathing:
____ I have been told that I stop breathing while I sleep.
____ I wake up at night choking, smothering or gasping for air.
____ I have been told that I snore.
____ I have been told that I snore only when sleeping on my back.
____ I have been awaken by own snoring.

Restlessness
____ I have uncomfortable feelings in my legs and/or arms when I lie down at night.
____ I have to move my legs or walk to relieve the uncomfortable feelings in my legs.
____ I am a restless sleeper.
____ I have been told that I jerk or kick my legs and/ or arms during sleep.
____ I have a hard time falling asleep because of my leg movements.
____ I have talked in my sleep as an adult.
____ I have walked in my sleep as an adult.
____ I grind my teeth in m sleep.

Daytime Sleepiness
____ I take daytime naps.
____ I have a tendency to fall asleep during the day.
____ I have had black outs or periods when I am unable to remember what just happened.
____ I have fallen asleep while driving.
____ I have had auto accidents as a result of falling asleep while driving.
____ I fall asleep while watching TV.
____ I fall asleep during conversations.
____ I fall asleep in sedentary situations.
____ I performed poorly in school because of sleepiness.
____ I have had injuries as a result of sleepiness.
____ I have had sudden muscle weakness in response to emotions such as laughter, anger or surprise.
____ I have had an inability to move while falling asleep or when waking up.
____ I have had hallucinations or dream-like images or sounds when falling asleep or waking up.
____ I drink caffeinated beverages during the day: _____ cups/ bottles/ cans per day.

Social History:
____ Sleeps alone.
____ Share a bed with someone.
____ Share a bedroom, but have separate beds.
____ Share a dwelling but have separate bedrooms.

Employment Status:
__ Employed __unemployed ___ retired.
____ My job requires driving a vehicle.
____ I work with dangerous equipment or substances.
____ I am a shift worker on rotating shifts.
____ I am a permanent or long term third shift worker.
____ I am currently a student.

17.. Please list any medical conditions that you have or have had in the past:
Please check applicable items:

____ Diabetes mellitus	_____ Hypertension	___Coronary artery disease
____ Heart attack	_____ Stroke	___ Asthma
____ Heart disease	_____ Reflux / GERD	___ COPD/Emphysema
____ Fibromyalgia	_____ TIA/ Light stroke	___ Black outs
____ Seizures	_____ Cancer	___ Back or joint problems (arthritis)
____ Thyroid problems	_____ Hepatitis/ jaundice	___ Hearing impairment
____ Depression	_____ Alcoholism	___ Chemical dependency/ abuse
____ Traumatic Brain Injury (TBI)	____Post Traumatic Stress Disorder (PTSD)	

Other Medical Conditions:_____
_____
_____
_____

18. Please list all medications and dosages that you are currently taking:

_____
_____
_____
_____
_____
_____

19. Are you allergic to any medicines? _____Yes _____No
If so, please list_____

20. Please list all surgeries that you have had_____
_____

21. Is your father alive? _____Yes _____No If not, what did he die of?_____
_____

22. Is your mother alive? _____Yes _____No If not, what did she die of _____
_____

32. Please check off any symptoms you have had for 2 weeks or more:

_____Loss of interest in things you used to enjoy, including sex
_____Feeling sad, blue or down in dumps.
_____Feeling slowed down or restless and unable to sit still
_____Feeling worthless or guilty
_____Changes in appetite or weight loss or weight gain
_____Problems concentrating, thinking, remembering or making decisions
_____Trouble sleeping or sleeping too much
_____Loss of energy or feeling tired all the time
_____Headaches
_____Other aches and pains
_____Digestive problems
_____Feeling pessimistic or hopeless
_____Being anxious or worried

33. Epworth sleepiness Scale:

Please read the list of situations and answer how likely you would be to doze off or fall asleep at these times, in the past three weeks. Write in the blank space as follows:

0 - Would never doze
1 - Slight chance of dozing
2 - Moderate chance of dozing
3 - High chance of dozing

Sitting and reading: _____
Watching television: _____
Sitting quietly in a public place (Ex. Theater or meeting) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting and talking with someone _____
Sitting quietly after a lunch without alcohol _____
In a car, while stopped for a few minutes in the traffic _____

Total Score (maximum = 24) _____

BERLIN QUESTIONNAIRE

Height (m) _____ Weight (kg)_____ Age_____ Male / Female

Please choose the correct response to each question.

CATEGORY 1

1. **Do you snore?**

_ a. Yes
_ b. No
_ c. Don't know

If you snore:

2. **Your snoring is:**

_ a. Slightly louder than breathing
_ b. As loud as talking
_ c. Louder than talking
_ d. Very loud – can be heard in adjacent rooms

3. **How often do you snore**

_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

4. **Has your snoring ever bothered other people?**

_ a. Yes
_ b. No
_ c. Don't Know

5. **Has anyone noticed that you quit breathing during your sleep?**

_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

CATEGORY 2

6. **How often do you feel tired or fatigued after your sleep?**

_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

7. **During your waking time, do you feel tired, fatigued or not up to par?**

_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

8. **Have you ever nodded off or fallen asleep while driving a vehicle?**

_ a. Yes
_ b. No

If yes:

9. **How often does this occur?**

_ a. Nearly every day
_ b. 3-4 times a week
_ c. 1-2 times a week
_ d. 1-2 times a month
_ e. Never or nearly never

CATEGORY 3

10. **Do you have high blood pressure?**

_ Yes
_ No
_ Don't know