Sleep Questionnaire

Fax or mail this to one of the addresses on the back on this brochure.

Comprehensive Sleep Medicine Associates
CSMA

Name: _____ Age: _____ Gender ❍ M ❍ F Date: _____

Ht: ____ft ____ in Wt: ____lbs Birth Date _____ Phone: Hm _____ Wk _____ Cell _____ Email _____

Preferred location for evaluation:

❍ **Houston** Fax 713-668-4105
❍ **Sugar Land** Fax 281-239-6268
❍ **The Woodlands** Fax 281-297-6436
❍ **Austin** Fax 512.691.7080

Completion of the boxed sections is critical for processing. Fax this form to the center near you.

1. Have you ever had a sleep evaluation before? ❍ Yes ❍ No
   If yes, are you currently using a treatment device regularly? ❍ Yes ❍ No
   If yes then what type of device? _____
   Your responses below should be in the context of how you are while using your device.
2. What time do you typically go into bed? _____
   When do you typically wake up to start your day? _____
3. Do you have difficulty *falling* asleep? ❍ Yes ❍ No
   If yes, about how long does it take to fall asleep? _____
   or fall back asleep? _____
   If Yes, do you plan your next day while lying in bed trying to fall asleep? ❍ Yes ❍ No
   If Yes, do you have racing thoughts going through your mind while trying to fall asleep? ❍ Yes ❍ No
4. **Do you have difficulty *staying* asleep? ❍ Yes ❍ No**
   If yes, how many awakenings per night? _____
   Average time to return to sleep? _____
5. **Do you take medications to fall or stay asleep? ❍ Yes ❍ No**
   If yes, name and dose _____
6. Do you feel un-refreshed when you awaken to start your day? (non-restorative sleep) ❍ Yes ❍ No
7. Do you experience an unsettled, *restless* sensation in your legs while lying in bed while awake? ❍ Yes ❍ No
   If yes, how often? ❍ Rarely (25%) ❍ Half the time (50%) ❍ Most of the time (75% or more)
   If yes, does movement of your legs calm down the restless sensations at least briefly? ❍ Yes ❍ No
8. Have you been told that you kick or twitch your legs while you are asleep? ❍ Yes ❍ No
9. **Do you *snore* at night? ❍ Yes ❍ No**
   If yes, how would you rate the severity?
   ❍ Mild ❍ Moderate ❍ Severe
10. **Have others told you that you have *pauses* in breathing or *gasping* sounds while sleeping? ❍ Yes ❍ No**
    If yes, how frequent are the pauses or gasping?
    ❍ Throughout the night ❍ Frequently ❍ Occasionally
11. Does your bed partner frequently sleep in another room because of how you sleep? ❍ Yes ❍ No ❍ No bed Partner
12. Check those that apply to you. Do you frequently wake up with:
    ❍ a dry mouth ❍ headaches ❍ excessive sweating ❍ heart burn
    ❍ chest pain ❍ clenching jaws (or grinding teeth) in sleep
    ❍ aching in jaws or TMJ pain ❍ choking or gasping
    ❍ drooling on the pillow ❍ bed wetting (loss of bladder control)
    ❍ nasal congestion on awakening (which was not present when you went to bed)
13. Do you have unusual behaviors in your sleep? ❍ Yes ❍ No
    If yes, how often? _____ When did this start to occur? _____
    If yes, briefly describe what you do in your sleep:
    _____
    If yes, what part of the night do these typically occur?
    ❍ Within the first 90 minutes ❍ First 3 hrs ❍ Last 3 hrs of sleep
14. Do you have difficulty maintaining concentration during the day? ❍ Yes ❍ No
15. **Are you *sleepy* during the day? ❍ Yes ❍ No**
16. Do you take naps often? ❍ Yes ❍ No
    If yes, for how long? _____
    Do you usually dream during these naps? ❍ Yes ❍ No
17. Daily consumption of: Caffeinated beverages _____ Alcoholic drinks _____ Tobacco Products _____
18. Do you occasionally awaken feeling *paralyzed*? ❍ Yes ❍ No
19. Do you experience *sudden loss* of strength in your legs or arms during the day? ❍ Yes ❍ No
    If yes, is it brought on by a sudden frightening event or laughter? ❍ Yes ❍ No

Rank how likely it would be for you to become drowsy (like you're going to fall asleep) during the day in the following situations—in contrast to feeling just tired in the following situations?

0 = never become drowsy 1 = rarely become drowsy
2 = frequently become drowsy 3 = always become drowsy

Chance of Becoming Drowsy				Situations
0	1	2	3	Sitting and reading
0	1	2	3	Watching TV
0	1	2	3	Sitting, inactive in a public place (e.g. theater)
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 to 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 the traffic

USE A SEPARATE SHEET OF PAPER IF NEEDED TO ANSWER THE QUESTIONS BELOW (not the back of this page)

My sleep problems are: _____
My other medical problems are: _____
My medications are: _____

Have you had a sleep study before? ❍ Yes ❍ No
If so then When and Where? _____
Can you get report? ❍ Yes ❍ No
Have you had surgery for sleep apnea before? ❍ Yes ❍ No
Do you have COPD? ❍ Yes ❍ No
Do you use Oxygen at night? ❍ Yes _____L/min ❍ No
Do you need assistance by others during the night? ❍ Yes ❍ No

Who filled out this questionnaire? _____

Referring Physician _____
Physician Phone Number _____
Insurance _____
Group Number _____ Policy Number _____