



OHSU Pulmonary Clinic
 Physicians Pavilion – Suite 320
 3181 SW Sam Jackson Park Road, UHN 67
 Portland, OR (503) 494-1620

Your physician has requested that you have a consultation regarding sleep related problems. Prior to this consultation, we request that you complete this questionnaire.

Please bring the completed questionnaire, your CPAP machine and any prior medical records to the clinic when you come for your consultation. If you have any questions, please call the OHSU Pulmonary Clinic at (503)494-1620

Name: _____ Gender: Male Female
 First Middle Last

Date: _____ Age: _____ Current Occupation: _____

Height: _____ feet _____ inches Current Weight: _____ lbs Allergies: _____

What is your primary problem with sleep? _____

How long have you had the sleep problem? _____ months _____ years
 List other problems with your sleep (indicate duration in months/years)

a). _____ b). _____
 c). _____ d). _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing 1= slight chance of dozing 2 = moderate chance of dozing 3= high chance of dozing

PLEASE CIRCLE ANSWER

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater or a 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 to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE _____

SPOUSE, SIGNIFICANT OTHER OR ROOMMATE QUESTIONNAIRE

Please check any of the following behaviors you have observed from spouse, significant other or roommate

While asleep you observe:

- | | | |
|--|--|--|
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Kicking of Legs | <input type="checkbox"/> Grinding Teeth |
| <input type="checkbox"/> Light Snoring | <input type="checkbox"/> Twitching of Legs or Feet | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Sleep Talking | <input type="checkbox"/> Sitting Up in Bed, Not Awake | <input type="checkbox"/> Pauses in Breathing |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Getting Out of Bed, Not Awake | |

While awake you observe:

- | | | |
|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Change in Personality | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Loss of Intellectual Function | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Excessive Daytime Sleepiness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Morning Headache | |

HISTORY OF SLEEP DISORDERS

Have you had a sleeping problem diagnosed in the past? Yes No

If yes what was the problem and what treatment(s) was/were recommended? _____

Have you had an overnight sleep study? Yes No

If yes what was the problem and what treatment(s) was/were recommended? _____

Did the treatment(s) help? Yes No Where was the diagnosis made? _____

Did you have a sleep problem as a Child? Yes N

If yes, describe _____

CURRENT SLEEP HABITS

What time do you usually go to bed on weekdays or days that you work? _____ AM PM

What time do you usually get up on weekdays or days that you work? _____ AM PM

What time do you usually go to bed on weekends or days you don't work? _____ AM PM

What time do you usually get up on weekends or days you don't work? _____ AM PM

How many hours do you usually sleep on weekdays or days that you work _____ AM PM

How many hours do you usually sleep on weekend days or days that you don't work? _____ AM PM

If you could set your own schedule, what time would you go to bed? _____ AM PM

what time would you get up? _____ AM PM

Do you currently do shift work? Yes No

Have you done shift work in the past? Yes No

Do you nap during the day? Yes No If yes, how many naps per day and how long on the average:

Number of naps per day _____ Average length (minutes) _____

Weekdays (work days) _____

Weekends (days not working) _____

Are you refreshed by your naps? Yes No

Do you keep a TV or radio on while you sleep? Yes No

Do you worry in bed? Yes No

Are you refreshed by a typical night's sleep? Yes No

Do you often have trouble getting to sleep at night? Yes No

What is the average number of minutes it takes you to fall asleep at night? _____ minutes

Do you often have awakenings during the night? Yes No

If yes, average number of times per night? _____

If yes, why do you awaken? _____

Do you have long periods when you awaken and are not able to get back to sleep? Yes No

If yes, how long are these periods of wakefulness when added together? _____ minutes per night

Are you bothered by waking up too early and not being able to get back to sleep? Yes No

If yes, what is the average number of nights per week? _____ nights per week

How many nights a week do you feel you have a sleep problem? _____ nights per week

Is your sleep disrupted by your bed partner, a child or a pet? Yes No

If yes, what disturbs you? snoring movement other _____

MOVEMENTS DURING SLEEP

Are your bedcovers extremely messy in the morning when you wake up? Yes No

Do you awaken yourself by kicking your legs during the night? Yes No

Has your bed partner ever complained of your legs kicking during the night? Yes No

Do you have a restless sense of discomfort (crawling sensation) in your legs during the waking hours? Yes No

NIGHTTIME SIGNS & SYMPTOMS

Do you eat during sleep? Yes No

Do you currently have nightmares or night terrors? Yes No

If yes, how frequently? _____ per week, _____ per month, or _____ per year

What age did they begin? _____ years

Do you grind or clench your teeth at night? Yes No

Have you ever been told that you walk in your sleep? Yes No

If yes, at what age? _____ years

Have you ever been told you scream, shout or make unusual movements such as swinging arms about, acting out dreams, etc. during sleep? Yes No

If yes, how frequently? _____ per week, _____ per month, or _____ per year

What age did they begin? _____ years

Please describe _____

Have you ever caused injury to yourself or others when you were asleep? Yes No

If yes, how frequently? _____ per week, _____ per month, or _____ per year

Please describe _____

SLEEP HISTORY

Do you feel excessively sleepy in the daytime? Yes No If yes, how long? _____ months, or _____ years

Do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes No

Do you feel your sleepiness is caused by any drug you are taking? Yes No

Have you ever had an accident or near-miss accident because of falling asleep driving? Yes No

If yes, describe _____

Have you ever felt sudden muscle weakness when you laughed, got angry, or were surprised? Yes No

Have you ever been unable to move your body just as you were falling asleep or waking up? Yes No

Have you ever experienced visions or hallucinations as you were falling asleep or waking up? Yes No

If yes, describe _____

How often do you wake with morning headaches: Never Monthly Weekly Daily

How often do you wake up with a dry mouth or sore throat? Never Monthly Weekly Daily

Have you been told that you stop breathing during sleep? Yes No

Have you ever awoken with a snort, choking sensation, or shortness of breath? Yes No

How often do you snore? Never Monthly Weekly Nightly

How loud is your snoring? Not Very Somewhat Very

In which position(s) do you prefer to sleep? Back Right Side Left Side Stomach

Do you have difficulty breathing through your nose? Yes No

If yes, describe _____

Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)? Yes No

If yes, describe _____

Do you have heartburn, gastric reflux, or a hiatal hernia? Yes No

Do you use oxygen or any type of medical equipment when you sleep? Yes No

If yes, describe _____

WEIGHT HISTORY

Please recall your weight history Enter N/A if not applicable

Weight at age 20 _____ lbs.

Weight at age 50 _____ lbs.

Weight at age 30 _____ lbs.

Weight at age 60 _____ lbs.

Weight at age 40 _____ lbs.

Heaviest weight _____ lbs., at _____ years

MEDICAL /SURGICAL/ PSYCHIATRIC HISTORY

Please list your current medical problems such as high blood pressure, heart disease, stroke, lung disease, etc

a). _____

b). _____

c). _____

d). _____

Do you experience any problem with sexual function? Yes No

Do you ever feel depressed? Never Rarely Occasionally Frequently Always

Do you feel depressed now? Yes No Do you feel anxiety now? Yes No

Have you ever seen a psychiatrist or any other type of counselor? Yes No Currently? Yes No

FAMILY HISTORY

Do any members of your family have?

Snoring Sleep Apnea Restless Legs Syndrome Sleep Walking Narcolepsy

SOCIAL HISTORY

Have you ever smoked cigarettes? Yes No Do you currently smoke cigarettes? Yes No

If yes, estimate the average packs of cigarettes per day while you were smoking _____

Years of cigarette smoking _____

OHSU Pulmonary Clinic - Sleep Disorders Questionnaire

If you quit smoking, when did you quit? _____

Have you ever smoked cigars, pipe, or chewed tobacco? Yes No Currently? Yes No

Please indicate the number of cups per day consumed of the following beverages
 caffeinated coffee (8 oz) _____ caffeinated tea (8 oz) _____ caffeinated soft drinks (12 oz) _____

Do you currently smoke marijuana or take any other street drugs? Yes No
 If yes, what and how often? _____

Did you ever drink alcohol? Yes No Do you currently drink alcohol? Yes No
 If yes, on average, how many alcoholic drinks do you take on weekdays (working days)? _____ per day

On the average, how many alcoholic drinks do you take on weekends (nor-working days)? _____ per day

Additional comments regarding sleep from you or your spouse? _____

REVIEW OF SYSTEMS

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Change in Sleep Habits <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Pain-Location <input type="checkbox"/> Other 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Other 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other 	<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fast Heart Beat <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Other
<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Memory Changes <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Weakness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Headache <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Changes <input type="checkbox"/> Unbalanced Walking <input type="checkbox"/> Other 	<p>Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Burning <input type="checkbox"/> Frequency <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Dribbling <input type="checkbox"/> Unable to Control Bladder <input type="checkbox"/> Other <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Rash <input type="checkbox"/> Changes in Moles <input type="checkbox"/> Open Sores <input type="checkbox"/> Other 	<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Other <p>Hematological</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Other 	<p>Breast</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Changes <input type="checkbox"/> Lumps <input type="checkbox"/> Other <p>Female Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Unusual Bleeding/Discharge <input type="checkbox"/> Birth Control <input type="checkbox"/> Other
<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Falls/Trauma <input type="checkbox"/> Other 	<p>Ears/Nose/Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sores in Mouth/Throat <input type="checkbox"/> Sore Throat 	<p>Mental Function</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Worried <input type="checkbox"/> Anxious <input type="checkbox"/> Sad/Depressed <input type="checkbox"/> Other 	<p>Male Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Problems Passing Urine