



Memorial Hospital Sleep Center

Rock Springs, Wyoming 82901

Sleep lab Phone: 307-352-8229 (Mon - Wed 5:00 pm – 7:00 am)

Office Phone: 307-352-8390 (Mon – Fri 8:00 am – 4:00 pm)

Patient Name: _____ Sex _____ Age _____ Date _____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP) _____

Marital status: Single Married Divorced Widowed

Are you currently using oxygen at night? ____ . If yes how many liters? ____

Please complete the following questionnaire by filling in the blanks and placing a check or circle in appropriate areas.

My Main Sleep Complaint (s) is:

___ Trouble sleeping at night For how many months/years? _____

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

___ Snoring For how many months/years? _____

___ Night choking, smothering or gasping for air. For how many months/years? _____

___ Other, Explain _____

<u>Sleep Pattern</u>	Work Days (weekday)	Off Days (Weekends)
----------------------	---------------------	----------------------

Typical bedtime:	_____	_____
------------------	-------	-------

Typical amount of time to fall asleep:	_____	_____
--	-------	-------

Typical number of awakenings per night:	_____	_____
---	-------	-------

List any activities that you normally do during nighttime awakenings(s)

(i.e. restroom, eat, watch TV) : _____

Typical amount of time it takes for you to

fall back to sleep after an awakening: _____

Typical wake up time: _____

Desired wake up time: _____

How do you usually awaken:

(i.e. alarm clock) _____

Typical time you get out of bed: _____

Total amount of sleep per night: _____

Number of naps per day: _____

Please check all of the following statements that are true about you sleep:

Sleep Habits:

Breathing

1. ___ I have been told that I stop breathing while sleep.
2. ___ I awaken at night choking, smothering or gasping for air.
3. ___ I have been told that I snore.
4. ___ I have been told that I snore only when sleeping on my back.
5. ___ I have been awakened by my own snoring.

Restlessness

1. ___ I am a restless sleeper.
2. ___ I kick or jerk my legs and/or arms during sleep.
3. ___ I experience restlessness, tingling or crawling in my arms or legs.
4. ___ I experience an inability to keep my legs still prior to falling asleep.
5. ___ I talk in my sleep as an adult.
6. ___ I have sleep walked as an adult.
7. ___ I grind my teeth in my sleep.

Daytime Sleepiness

1. ___ I take daytime naps.
2. ___ I have a tendency to fall asleep during the day.
3. ___ I have experienced lapses in time or blackouts.
4. ___ I have fallen asleep while driving.
5. ___ I have had auto accidents as a result of falling asleep while driving.

6. ___ I fall asleep while watching TV.
7. ___ I fall asleep during conversations.
8. ___ I fall asleep in sedentary situations.
9. ___ I performed poorly in school because of sleepiness.
10. ___ I have had injuries as the result of sleepiness.
11. ___ I have experienced sudden muscle weakness in response to emotions such as such as laughter, anger or surprise.
12. ___ I have experienced an inability to move while falling asleep or when waking up.
13. ___ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up.
14. ___ I drink caffeinated beverages during the day ___ cups/bottles/cans per day

Habits

1. Do you smoke? Yes No
- If yes what? Amount per day: For how many years?
2. Cigarettes _____ _____
3. Cigars _____ _____
4. Tobacco _____ _____

5. Do you drink alcohol? Yes No
6. If yes what?

Frequency: Amount per week

Circle answers:

7. Beer Daily Weekends Rare ___ cans/week
8. Wine Daily Weekends Rare ___ glasses/week
9. Liquor Daily Weekends Rare ___ shots/week

Social History

10. Marital Status: Single Married Separated Divorced Widowed
11. ___ sleep alone
12. ___ share a bed with someone
13. ___ share a bedroom, but have separate beds
14. ___ share a dwelling, but have separate bedrooms

Employment Status : Employed Unemployed Retired

15. ___ My job requires driving a vehicle
16. ___ I work with dangerous equipment or substances
17. ___ I am a shift worker on rotating shifts
18. ___ I am a permanent or long term third shift worker

19. ___ I am currently a student

Medical History

Vital Statistics

What is your: Height_____ Weight _____ What was your weight one year ago_____?

Current Medications

Medication	Dose	# Times Per Day
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____

Allergies: _____

Past Sleep Evaluation and Treatment

1. ___ I have had a previous sleep disorder evaluation
2. ___ I have had a previous overnight sleep studies
3. ___ I have had daytime nap studies
4. ___ I have been prescribed a CPAP or BI-Level machine for home use
5. ___ I have had a surgical treatment for a sleep disorder
6. ___ I have previously been prescribed medication for a sleep disorder
7. ___ I have been previously treated for a sleep disorder

Past Medical History

- ___ Hypertension (High blood Pressure)
- ___ Heart Disease
- ___ Diabetes
- ___ Stomach or colon problems
- ___ Lung problems/COPD/asthma
- ___ Reflux
- ___ Fibromyalgia
- ___ Stroke
- ___ Tia” Light Stroke”
- ___ Chemical dependency or abuse
- ___ Black outs
- ___ Seizures
- ___ Back or joint problems (arthritis)
- ___ Cancer
- ___ Thyroid Problems
- ___ Hepatitis/jaundice
- ___ Hearing impairment
- ___ Depression or severe anxiety
- ___ Alcoholism

1. Female

2. ___Premenstrual Syndrome
3. ___Menopause
4. Male
5. ___ Prostate problems
6. ___Erectile dysfunction/impotence

List other past medical problems and dates:

- _____
- _____
- _____
- _____

Using the answer key , please circle the number that best applies to your life over the past 6 months.

1 =Never (strongly disagree) 2 =Rarely(disagree) 3 =Sometimes (not sure)
 4 = Usually (agree) 5 = Always (agree strongly)

- | | | | | | |
|--|---|---|---|---|---|
| 1. I have trouble getting to sleep | 1 | 2 | 3 | 4 | 5 |
| 2. I wake up often during the night | 1 | 2 | 3 | 4 | 5 |
| 3. At bedtime thoughts race through my mind | 1 | 2 | 3 | 4 | 5 |
| 4. At bedtime, I feel sad and depressed | 1 | 2 | 3 | 4 | 5 |
| 5. When falling asleep, I feel paralyzed
(unable to move) | 1 | 2 | 3 | 4 | 5 |
| 6. When falling asleep, I have a “restless legs”
(a feeling of crawling, aching, or inability
to keep legs still) | 1 | 2 | 3 | 4 | 5 |
| 7. I awake suddenly gasping for breath, unable
to breathe | 1 | 2 | 3 | 4 | 5 |
| 8. at night my heart pounds, beats rapidly, or
beats irregularly (‘palpitations’) | 1 | 2 | 3 | 4 | 5 |
| 9. I sweat a great deal at night | 1 | 2 | 3 | 4 | 5 |
| 10. My sleep is disturbed by “restless legs”
(a feeling of crawling or aching or inability to
Keep legs still) | 1 | 2 | 3 | 4 | 5 |
| 11. My sleep is disturbed by sadness or depression | 1 | 2 | 3 | 4 | 5 |
| 12. I have a lot of nightmares (frightening dreams) | 1 | 2 | 3 | 4 | 5 |
| 13. I feel unable to move (paralyzed) after a nap | 1 | 2 | 3 | 4 | 5 |
| 14. I have dream-like images (hallucinations) when
I awaken in the morning even though I know I
am not asleep | 1 | 2 | 3 | 4 | 5 |
| 15. I have slept for several days at a time, or
at least I have been overwhelmingly sleepy | | | | | |

for that long	1	2	3	4	5
16. I have been unable to sleep at all for several days.	1	2	3	4	5
17. I feel that I have insomnia	1	2	3	4	5
18. Now, I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
19. In the past 6 months, I have fallen asleep accidentally in some of these situations: eating a meal, talking on the phone, talking to someone, riding in a bus or car, watching TV at a theater, reading a book, at a lecture	1	2	3	4	5
20. I got bad grades in school because I was to sleepy	1	2	3	4	5
21. I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
22. I often have to let someone else drive the Car because I am too sleepy to do it	1	2	3	4	5
23. I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am awake when they happen	1	2	3	4	5
24. I am often unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
25. Sometimes I realize I have driven my car to the wrong place, and I can't remember how how I did it	1	2	3	4	5
26. I get "weak knees" when I laugh I get sudden muscular weakness (or even a Brief period of paralysis, being unable to move) When laughing, angry, or in situations of strong emotions.	1	2	3	4	5
27. I have high blood pressure (or once had it)	1	2	3	4	5
28. My desire or interest in sex is less than what It used to be	1	2	3	4	5
29. I am unhappy about loving relationships in my life	1	2	3	4	5
30. I have considered or attempted suicide	1	2	3	4	5
31. Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
32. I smoke tobacco within two hours before bedtime	1	2	3	4	5
33. I have problems with my nose blocking up when I am trying to sleep					

(allergies, infections)	1	2	3	4	5
34. My snoring or bed breathing problem is much worse if I sleep on my back	1	2	3	4	5
35. My snoring or my breathing problem is much worse if I fall asleep right after drink	1	2	3	4	5