Sleep Questionnaire

Personal Information

Name:	Date of birth:	Sex:
Marital Status:	Nationality:	MRN:
Address:	Mobile:	Telephone:
Email:	Referring Physician:	Referring Hospital:
Occupation:	Length of work day:	Does Your work involve shift work?
Work Address:		

Main Complaint:

Instructions:

The following questions relate to your usual sleep habits the **past month only**. Your answers should indicate the most accurate reply for the **majority of days and nights in the past month**. Please answer all questions.

During the past month

1.What time have You usually gone to bed at night?

2.How long (in minutes) has it usually taken you to fall asleep each night?

3.What time have you usually gotten up in the morning?

4.How many hours of actual sleep did you get at night?
(This may be different than the actual hours you spent in bed)

If you have a roommate or bed partner, ask him/ her how often in the past month these situations have happened

	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
1. Loud snoring	○	○	○	○
2. Long pauses between breaths while asleep	○	○	○	○
3. Legs twitching or jerking while asleep	○	○	○	○
4. Episodes of disorientation or confusion during sleep	○	○	○	○
5. Other restlessness while you sleep; please describe				
6. How many times did this happen during the past month?	○	○	○	○

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. Use the following scale to choose the most appropriate number for each situation.

Situation	Would Never Dose (0)	Slight Chance of Dozing (1)	Moderate Chance of Dozing (2)	High Chance of Dozing (3)
Sitting and Reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive in a public place	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○
Total:........../24	**Interpretation:** **Excessive Daytime Sleepiness:** ○ Yes ○ No			

Stop-Bang Questionnaire:

	Yes	No
Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	○	○
Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving)?	○	○
Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?	○	○
Do you have or are being treated for **High Blood Pressure?**	○	○
Body Mass Index more than 35 kg/m2?	○	○
Age older than 50 year old?	○	○
Neck size large? (Measured around Adams apple) For male, is your shirt collar 17 inches/43 cm or larger? For female, is your shirt collar 16 inches/41 cm or larger?	○	○
Gender = Male?	○	○
***Total:** .... **Low risk**: Yes to 0-2 questions **Intermediate risk**: Yes to 3-4 questions **High risk**: Yes to 5-8 questions or Yes to 2 or more of 4 STOP questions + male gender or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m2 or Yes to 2 or more of 4 STOP questions + neck circumference (17”/43cm in male, 16”/41cm in female)	**Interpretation:** Risk for obstructive sleep apnea: ○ High ○ Intermediate ○ Low	

Restless Leg Syndrome:

During the past month, have you had the following complaints?

Condition	Yes	No
Had trouble sleeping because you felt an urge to move your legs, usually accompanied or caused by uncomfortable and unpleasant sensations in the legs.	○	○
You felt the urge to move, or unpleasant sensations that begin or worsen during periods of rest or inactivity such as lying or sitting.	○	○
You felt the urge to move, or unpleasant sensations that are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues.	○	○
You felt the urge to move, or unpleasant sensations that are worse in the evening or night than during the day or only occur in the evening or night.	○	○
Any similar family history?	○	○
***Interpretation:**	**Restless Leg Syndrome:** ◯ Yes ◯ No	

- **Do you ever wake up and feel paralyzed?** ◯ Every night ◯ Occasionally ◯ Never

- **When you are angry, excited, or laughing, do you feel weakness at the knees?**
  ◯ Every night ◯ Occasionally ◯ Never

- **Has your nose ever been broken** ◯ Yes ◯ No, If Yes, When? ________

- **Can you breathe well through both nostrils?** ◯ Yes ◯ No

- **How much coffee/tea/cola do you drink per day?**

Type of Drink	Number of Cups
Coffee	
Tea	
Cola	

Please check whether a doctor has told you that you had or have each condition below:

Diagnosis	Yes	No
Emphysema or COPD	○	○
Chronic Bronchitis or Asthma	○	○
Allergic Rhinitis	○	○
Angina or Coronary Heart Disease or Arteriosclerosis	○	○
Heart attack	○	○
Stroke	○	○
Hypertension or High Blood Pressure	○	○
Diabetes	○	○
Hypothyroidism	○	○
Mention if there is another diagnosis:		

Do you take any medication? If yes please list all medications you are currently taking:

Medication	Dosage	Reason	Since when

Physical Exam

Height	___________	Mallampati Score	___________
Weight	___________	BP	___________
B.M.I	___________	Epworth Score (Degree of Sleepiness)	___________
Neck Circumference	___________	STOP BANG Score (Risk for Sleep apnea)	___________

Comment:

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Impression:

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Plan:

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Physician Name: ___________________________

Signature: ___________________________________

Date: _______________________________________

Consultant Name: ___________________________

Signature: ___________________________________

Date: _______________________________________