Anesthesia & Sleep Medicine Services of Florida

Phillip A. Nye, MD, FASA
Diplomate of the American Board of Anesthesiology
& Sleep Medicine Specialist

SLEEP DISORDER SCREENING QUESTIONNAIRE

NAME (LAST, FIRST, MI)			SSN	
ADDRESS (STREET OR BOX NO.)				
CITY		STATE	ZIP	
TELEPHONE (HOME)	TELEPHONE (WORK)	DATE OF BIRTH	AGE	SEX (CIRCLE ONE) M F
OCCUPATION	WORKING HOURS FROM _____ TO _____			
REFERRING PHYSICIAN				
REFERRING PHYSICIAN'S ADDRESS				

Height _____ Weight _____ Neck Size _____ Blood Pressure _____ Pulse _____

Any recent weight increase? ☐ Yes ☐ No How much _____ Over what time period _____

Any recent weight loss? ☐ Yes ☐ No How much _____ Over what time period _____

Reason for Sleep Study: ☐ Sleepiness ☐ Snoring ☐ Disturbed Sleep

SNORING:

1. How many years have you been told you snore? _____
2. Does your snoring disturb your bed partner? ☐ Yes ☐ No
3. Has your snoring become progressively worse? ☐ Yes ☐ No Over what period of time? _____
4. Have you been told you snore when sleeping? (*Circle all that apply*)
   On your back On your side On your stomach In a sitting position
5. On a scale of 1 to 5 (1 is minimal and 5 very loud), how loud is your snoring? _____
6. Which pattern best describes your snoring? (*Circle one*)
   a. Snoring is present almost continuously.
   b. Snoring is noted only occasionally and is not continuous.
   c. I snore loudly, then snoring and breathing stops, and then I snore loudly again.
7. Have you ever awakened from sleep because you are snoring? ☐ Yes ☐ No

NAME: _____

EXCESSIVE DAYTIME SLEEPINESS: (*Epworth Sleepiness Scale*)

1. Do you usually feel tired during the day? ☐ Yes ☐ No
2. 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 = would never

   1 = slight chance of dozing

   2 = moderate chance of dozing

   3 = high chance of dozing

SITUATION:	**CHANCE OF DOZING**
a. Sitting and reading	_____
b. Watching TV	_____
c. Sitting, inactive in a public place (e.g., a theater)	_____
d. As a passenger in a car for an hour without a break	_____
e. Lying down to rest in the afternoon when time permits	_____
f. Sitting and talking to someone	_____
g. Sitting quietly after a lunch without alcohol	_____
h. In a car, while stopped for a few minutes in traffic	_____

3. How many naps do you take per day? _____ Length _____

   Do you feel refreshed after a nap? ☐ Yes ☐ No
4. Do you experience drowsiness or a tendency to fall asleep while driving? ☐ Yes ☐ No
5. Have you been in a car accident due to falling asleep at the wheel? ☐ Yes ☐ No ☐ Near miss
6. Please describe an incident when you fell asleep during the day when you were not expected to fall asleep.

   _____

   _____

APNEA:

1. Have you ever been observed to stop breathing during sleep? ☐ Yes ☐ No
2. Do you wake up with dry mouth? ☐ Yes ☐ No
3. How many times do you awake to go to the bathroom? _____
4. Have you ever awakened choking or gasping for breath? ☐ Yes ☐ No
5. Upon awakening, do you feel refreshed and rested? ☐ Yes ☐ No

NARCOLEPSY: *(Sleepiness with dreaming and spells of weakness)*

1. Do you have sudden attacks of sleepiness? ☐ Yes ☐ No
2. Have you recently noticed increased irritability or trouble thinking? ☐ Yes ☐ No
3. Has daytime sleepiness affected your job performance of your employment? ☐ Yes ☐ No
4. Do you have cataplexy? ☐ Yes ☐ No
   (*Cataplexy is a brief (seconds or minutes) episode of muscle weakness; e.g., jaw drop, arm or leg weakness and/or paralysis. When the attack is over, the patient is completely normal. Laughter, anger, athletic activity, excitement are the usual factors that initiate an attack of cataplexy.*)
5. Do you have episodes of arm or leg paralysis (sleep paralysis) during sleep? ☐ Yes ☐ No
6. Do you hear or see something in the beginning or last part of sleep that is not real? (hallucinations) ☐ Yes ☐ No

NAME: _____

LEG PROBLEMS: *(Restless legs and compulsive leg moving at night)*

1. Do you have leg cramps at night? ☐ Yes ☐ No
2. Have you ever been told that your arms or legs move a lot at night? ☐ Yes ☐ No
3. Do you experience "creepy crawling" and/or aching feeling in your legs which make your want to move them? ☐ Yes ☐ No
4. Do you jerk your arms or legs during sleep? ☐ Yes ☐ No

SLEEP STATUS AND HABITS:

1. What do you usually do the hour before bed? _____
2. Do you often read in bed? ☐ Yes ☐ No
3. Do you often watch TV in bed? ☐ Yes ☐ No
4. Do you eat in bed? ☐ Yes ☐ No
5. During the night, do you often look at the clock? ☐ Yes ☐ No
6. On average, how long does it take you to fall asleep at night? _____ Min. _____ Hrs.
7. Do you have difficulty falling and/or staying asleep? ☐ Yes ☐ No
8. What time do you usually go to bed during the week? _____ Week-ends? _____
9. What time do you usually wake up during the week? _____ Week-ends? _____
10. How many times do you usually awaken during the night? ☐ 0-1 ☐ 2-3 ☐ more than 3
11. How many times do you usually awaken to urinate? ☐ 0-1 ☐ 2-3 ☐ more than 3
12. How long does it take to return to sleep? _____
13. Upon awakening, do you feel ☐ tired ☐ rested/refreshed ☐ other?
14. How many hours do you sleep at night? _____

MEDICAL HISTORY:

1. Do you have difficulty breathing through the nose? ☐ Yes ☐ No
2. Do you wear dentures? ☐ Yes ☐ No
3. Have you had any of the following:
   a. Tonsillectomy and/or adenoidectomy? ☐ Yes ☐ No When: _____
   b. Nasal or sinus surgery? ☐ Yes ☐ No When: _____
   c. Vocal cord surgery (polyp, nodules, etc.)? ☐ Yes ☐ No When: _____
   d. Any neck operations? ☐ Yes ☐ No When: _____
4. Have you been treated for sleep apnea? ☐ Yes ☐ No
   When: _____ Where: _____
   How: ☐ Tracheostomy ☐ UPP ☐ CPAP ☐ Drugs
   Did treatment improve: ☐ Sleepiness ☐ Snoring ☐ Tiredness ☐ Quality of sleep
5. Do you have any of the following:
   a. High blood pressure ☐ Yes ☐ No
   b. Heart disease ☐ Yes ☐ No
   c. Morning headaches ☐ Yes ☐ No
   d. Memory loss ☐ Yes ☐ No
   e. Sexual problems ☐ Yes ☐ No
   f. Lung disease ☐ Yes ☐ No
   g. Thyroid disease ☐ Yes ☐ No
   h. Allergy ☐ Yes ☐ No
   i. Swelling of your legs ☐ Yes ☐ No
   j. Urinary or kidney problems ☐ Yes ☐ No
   k. Stroke ☐ Yes ☐ No
   l. Diabetes ☐ Yes ☐ No
   m. Epilepsy ☐ Yes ☐ No
   n. Elevated cholesterol ☐ Yes ☐ No
   o. Any other neurologic disorder ☐ Yes ☐ No _____
   p. Any psychiatric disorder ☐ Yes ☐ No _____
   q. Any other problems ☐ Yes ☐ No _____

NAME: _____

6. Medications:

_____

_____

_____

_____

_____

_____

_____

Allergies to Any Medications: _____

_____

_____

7. General health: _____
8. Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ or cigarettes per day? _____
9. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per day?_____
10. Does alcohol affect your sleep? ☐ Yes ☐ No

    If yes, please describe: _____

    _____
11. How many caffeinated drinks do you have in a day? Coffee _____ Tea _____ Soda _____
12. Do you use prescription or non-prescription sleeping pills? ☐ Yes ☐ No

FAMILY HISTORY:

1. Anybody in your family snore? ☐ Yes ☐ No
2. Anybody in your family is very sleepy? ☐ Yes ☐ No
3. Anybody in your family diagnosed with sleep disorder? ☐ Yes ☐ No If yes, what? _____

ANY FURTHER COMMENTS REGARDING YOUR CONDITION NOT COVERED IN THIS FORM?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Can we use the medical information provided in this form for publications or teaching *(without identifying the patient)*?

☐ Yes ☐ No

NAME:_____ AGE:_____ SEX:_____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement that best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. (0) I do not feel sad.
   (1) I feel sad.
   (2) I am sad all the time and I can't snap out of it.
   (3) I am so sad or unhappy that I can't stand it.

2. (0) I am not particularly discouraged about the future.
   (1) I feel discouraged about the future.
   (2) I feel I have nothing to look forward to.
   (3) I feel that the future is hopeless and that things cannot improve.

3. (0) I do not feel like a failure.
   (1) I feel I have failed more than the average person.
   (2) As I look back on my life, all I can see is a lot of failures.
   (3) I feel I am a complete failure as a person.

4. (0) I get as much satisfaction out of things as I used to.
   (1) I don't enjoy things the way I used to.
   (2) I don't get real satisfaction out of anything anymore.
   (3) I am dissatisfied or bored with everything.

5. (0) I don't feel particularly guilty.
   (1) I feel guilty a good part of the time.
   (2) I feel quite guilty most of the time.
   (3) I feel guilty all of the time.

6. (0) I don't feel I am being punished.
   (1) I feel I may be punished.
   (2) I expect to be punished.
   (3) I feel I am being punished.

7. (0) I don't feel disappointed in myself.
   (1) I am disappointed in myself.
   (2) I am disgusted in myself.
   (3) I hate myself.

8. (0) I don't feel I am worse than anybody else.
   (1) I am critical of myself all the time for my faults.
   (2) I blame myself all the time for my faults.
   (3) I blame myself for everything bad that happens.

NAME: _____

9. (0) I don't have any thoughts of killing myself.
   (1) I have thoughts of killing myself, but I would not carry them out.
   (2) I would like to kill myself.
   (3) I would kill myself if I had a chance.

10. (0) I don't cry anymore than usual.
    (1) I cry more now than I used to.
    (2) I cry all the time now.
    (3) I used to be able to cry, but now I can't cry even though I want to.

11. (0) I am no more irritated now than I ever am.
    (1) I get annoyed or irritated more easily than I used to.
    (2) I feel irritated all the time now.
    (3) I don't get irritated at all by the things that used to irritate me.

12. (0) I have not lost interest in other people.
    (1) I am less interested in other people than I used to be.
    (2) I have lost most of my interest in other people.
    (3) I have lost all of my interest in other people.

13. (0) I make decisions about as well as I ever could.
    (1) I put off making decisions more than I used to.
    (2) I have greater difficulty in making decisions than before.
    (3) I can't make decisions at all anymore.

14. (0) I don't feel I look any worse than I used to.
    (1) I am worried that I am looking old or unattractive.
    (2) I feel that there are permanent changes in my appearance that make me look unattractive.
    (3) I believe that I look ugly.

15. (0) I can work about as well as before.
    (1) It takes an extra effort to get started at doing something.
    (2) I have to push myself very hard to do anything.
    (3) I can't do any work at all.

16. (0) I can sleep as well as usual.
    (1) I don't sleep as well as I used to.
    (2) I wake up 1-2 hours earlier than usual and it is hard to go back to sleep.
    (3) I wake up several hours earlier than I used to and cannot get back to sleep.

17. (0) I don't get more tired than usual.
    (1) I get tired more easily than I used to.
    (2) I get tired from doing almost anything.
    (3) I am too tired to do anything.

NAME: _____

18. (0) My appetite is no worse than usual.
    (1) My appetite is not as good as it used to be.
    (2) My appetite is much worse now.
    (3) I have no appetite at all anymore.

19. (0) I haven't lost much weight, if any, lately.
    (1) I have lost more than 5 pounds.
    (2) I have lost more than 10 pounds.
    (3) I have lost more than 15 pounds.

    I am purposely trying to lose weight by eating less. ☐ Yes ☐ No

20. (0) I am no more worried about my health than usual.
    (1) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    (2) I am very worried about physical problems and its hard to think of much else.
    (3) I am so worried about my physical problems that I cannot think about anything else.

21. (0) I have not noticed any recent change in my interest in sex.
    (1) I am less interested in sex than I used to be.
    (2) I am much less interested in sex now.
    (3) I have lost interest in sex completely.

TOTAL SCORE _____