Texas Pulmonary Sleep Center
Pre-Sleep Questionnaire

Pt. Name: ____ Date of Birth: ______________

SS ID #: __________________________ Current Ht. ______ Current wt. _________ Report past year wt changes:

☐ Loss ☐ Gain in past year: _________ LBS. Why?____

Have you ever had a sleep study? ☐ Yes ☐ No When? ________________ Where? ____________________

What was the outcome of the study? ____

CHIEF COMPLAINT

Check any of the following that apply:

[ ] Loud snoring

[ ] Breathing or snoring stops for brief periods in my sleep

[ ] Awaken gasping for breath

[ ] Do not feel restored when I awaken

[ ] Become sleepy during the day (please circle all that apply)

sitting talking watching T.V.
riding in car in theaters while driving standing

[ ] Can't fall asleep [ ] Can't stay asleep

Sleep complaints for:

[ ] 1 to 2 years

[ ] longer than 2 years

[ ] several months to 12 months

[ ] within the last 3 months

[ ] within the last month

SLEEP TREATMENT

I was previously diagnosed with:

[ ] Sleep apnea [ ] Restless legs syndrome [ ] Narcolepsy [ ] Periodic limb movements [ ] Insomnia

If yes to any of the above please explain: When? ________________ Where?____________________________

Treatment: ____

MEDICAL HISTORY

Please check if you have or have ever had any of the following treatments or medical conditions:

[ ] Oral Appliance [ ] CPAP or BiPAP Treatment - Settings ______________cmH20 pressure

[ ] Supplemental Oxygen with _____ liters/minute used approx. _____ hours per day or night (circle one)

[ ] Diabetes [ ] Depression [ ] Seizures [ ] Parkinson's disease

[ ] High blood pressure [ ] Asthma/Emphysema [ ] Reflux [ ] Thyroid condition

[ ] Fibromyalgia [ ] Anxiety [ ] Head Injury or brain surgery

[ ] Stroke [ ] Heart disease List type: [ ] Tonsillectomy [ ]Adenoidectomy

[ ] Uvulopalatopharyngoplasty (UPPP) [ ] Laser or other procedure on uvula (LAUP)

[ ] Sinus, deviated septum or turbinate reduction [ ] Mandibular surgery

[ ] Pain which disrupts sleep. The typical location[s] for this pain is/are: ___Headaches ___Neck ___Back
___Chest ___Limbs ☐ arm(s) ☐ leg(s) ___Abdominal ___Pelvic ___Joint (arthritis)

[ ] Other medical problems which may affect sleep (please list):____

____

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SYMPTOMS DURING SLEEP

Indicate if you experience the following symptoms when trying to sleep and after awakening:

Yes	No	Symptoms
		Memory impairment
		Inability to concentrate
		Fatigue
		Anxiety
		Depression
		Wakes with sore throat and hoarseness
		Morning headaches
		Wakes with a dry mouth
		Feeling tired and sleepy during the daytime
		Sudden paralysis or feel your body go limp when you are angry or excited
		Frequent arousals from sleep and cannot return to sleep
		Wakes for unknown reasons
		Restless sleep
		Confusion after awakening
		Creeping or crawling sensation in your legs before falling asleep
		Legs or arms jerking during sleep
		Sleep talking
		Sleep walking
		Nightmares
		Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
		Frequent urination disrupting sleep
		Teeth grinding
		Wheezing or cough disrupting sleep
		Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
		Shortness of breath disrupting sleep

MEDICATION

Do you take anything to help you sleep? ☐ Yes ☐ No What?______________________________

How often?______________________________ Prescribing physician: ______________________________

Are you allergic to anything? ☐ Yes ☐ No What? ______________________________

____

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List current medications and dosages, including both prescriptions and over-the-counter medications:

____

____

SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No How many years? __________

How much per day? __________Tobacco product used: ____

Do you drink alcohol? ☐ Yes ☐ No How much? ____ drinks per ☐day ☐week ☐month (indicate usual consumption

How much caffeinated coffee, tea or cola do you drink daily? _______________Describe: ________________________

ENVIRONMENT

Describe your bedroom ☐ loud ☐ quiet ☐ light ☐ dark

Describe your mattress ☐ soft ☐ hard ☐ just right

Do you go to sleep with the television on? ☐ Yes ☐ No If yes, do you use a sleep timer? ☐ Yes ☐ No

Is your sleep disturbed because of your bed partner or others in your household? ☐ Yes ☐ No

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.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading …………………………………………	__________
Watching TV …………………………………………	__________
Sitting, inactive, in a public place [e.g., a theater or a meeting] …………………	__________
As a passenger in a car for an hour without a break …………………	__________
Lying down to rest in the afternoon when circumstances permit …………………	__________
Sitting and talking with someone …………………………………	__________
Sitting quietly after a lunch without alcohol …………………………	__________
In a car, while stopped for a few minutes in traffic …………………	__________
Total	__________

Please sign and date below to confirm that you have answered these questions to the best of your knowledge and that you understand that this information is regarded as confidential and is only released to the sleep lab personnel and physicians involved in making your diagnosis. If you already have a medical equipment (DME) provider, please list the company name: ____. If you should require treatment with medical equipment and do not have a provider preference, a provider will be selected that participates in your network.

____ ______________________

Signature of patient or caregiver **Date**