FORT MADISON COMMUNITY HOSPITAL
SLEEP STUDIES CENTER

For Hospital Use Only

Place Label In this Area

INITIAL QUESTIONNAIRE

PERSONAL INFORMATION

Today's Date:

Name: _____
(Last) *(First)* *(M.I)*

Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Date of Birth:	Height:	Weight:	Neck Size in Inches:

Home Phone: ( )	Cell Phone: ( )
Occupation:	What shift do you work? :
Have you gained any weight recently? ☐ Yes ☐ No If so, how much?	Marital Status:
Referring Physician:	Physician Phone: ( )

PLEASE LIST YOUR DAILY MEDICATIONS

Name of Medication	Amount	How Often	When Last Taken

ALLERGIES TO MEDICATIONS

Please list any allergies to medications that you have and what reaction you experienced.

Medication	Reaction

SLEEP AND YOU

It is important for you to be accurate in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

1. Describe your main problem(s) in your own words, including when and how this began.

2. How long as this problem bothered you? ☐ Longer than 2 years ☐ 1-2 Years ☐ Several Months ☐ Within the last three months ☐ Within the last month

3. Please estimate the severity of your problem(s)
☐ Not Severe ☐ Very Severe ☐ Extremely Severe ☐ Totally Incapacitating

4. Do any other members of your family have sleep problems? ☐ Yes ☐ No
If yes, please explain:

5. How many hours of sleep do you usually get per night?

6. Is your sleep disturbed by: ☐ Cold ☐ Heat ☐ Light
☐ Noise ☐ Bed Partner ☐ Body Jerking ☐ To go to the bathroom
☐ Heartburn ☐ Other: _____

7. Are you usually drowsy/tired after an average night's sleep? ☐ Yes ☐ No
If yes, how long? ☐ 1 Hour ☐ 2 Hours ☐ 3 Hours ☐ Longer

8. What time do you normally go to bed on weekdays?	What time do you normally get up on weekdays?
9. What time do you normally go to bed on the weekends?	What time to you normally get up on the weekends?

10. On average, how long does it take you to fall asleep during the night?

11. How many times do you wake during the night?	12. During what part of the night are you most likely to wake?

13. Do you sleep better: ☐ In bed ☐ In an easy chair

14. Do you sleep better: ☐ At home ☐ Away from home

15. On average, what amount of each of these beverages do you drink each day?

____ Regular Coffee	____ Tea	____ Wine	____ Mixed Drinks
____ Decaffeinated Coffee	____ Cola	____ Beer	____ Hard Liquor

16. Do you take naps? ☐ Yes ☐ No If so, for how long? Do you feel refreshed after? ☐ Yes ☐ No

SLEEP HISTORY

Do you snore?	☐ Yes ☐ No	Do you have morning headaches?	☐ Yes ☐ No
Do others complain about your snoring?	☐ Yes ☐ No	Have you ever fallen asleep on the job?	☐ Yes ☐ No
Have you ever been told you stop breathing in your sleep?	☐ Yes ☐ No	Do you ever fall asleep at public gatherings?	☐ Yes ☐ No
Do you awake short of breath or choking?	☐ Yes ☐ No	Do you ever fall asleep while driving?	☐ Yes ☐ No
Do you have night sweats?	☐ Yes ☐ No	Do you ever fall asleep at work or	☐ Yes ☐ No

		school?	
Do you awaken with heartburn?	☐ Yes ☐ No	Do you have a history of seizures?	☐ Yes ☐ No
Do you experience weakness in the knees when laughing or angered?	☐ Yes ☐ No	Do you have a history of head trauma or loss of consciousness?	☐ Yes ☐ No
Do you experience vivid dreams upon awaking or falling asleep ?	☐ Yes ☐ No	Ever feel unable to move (paralyzed) when waking up or falling asleep?	☐ Yes ☐ No
Do you have leg cramps at bedtime?	☐ Yes ☐ No	Are the bedcovers in disarray in the morning?	☐ Yes ☐ No
Do you experience crawling or aching feelings in your legs?	☐ Yes ☐ No	Have you been told that you jerk or twitch in your sleep?	☐ Yes ☐ No
Do you notice the aching or crawling is worse at bedtime?	☐ Yes ☐ No	Do you awaken suddenly with a jerk after falling asleep?	☐ Yes ☐ No
Do you talk in your sleep?	☐ Yes ☐ No	Have you been told that you sleepwalk?	☐ Yes ☐ No
Do you remember your dreams?	☐ Yes ☐ No	Do you have nightmares?	☐ Yes ☐ No
Have you been told you act out your dreams?	☐ Yes ☐ No	Do you awaken feeling panicked or with your heart racing?	☐ Yes ☐ No
Have you hurt yourself or anyone else in your sleep without realizing?	☐ Yes ☐ No	Are you unable to fall asleep in 15 minutes or less?	☐ Yes ☐ No
Do you watch a clock while trying to sleep?	☐ Yes ☐ No	Do you have anxiety which keeps you from sleeping	☐ Yes ☐ No
Are you bothered by long periods of wakefulness during the night?	☐ Yes ☐ No	Are you bothered by waking up to early and not being able to get back to sleep?	☐ Yes ☐ No
Do you wake up feeling stiff in the morning?	☐ Yes ☐ No	Do you have racing thoughts while trying to fall asleep?	☐ Yes ☐ No
Do you have morning jaw pain?	☐ Yes ☐ No	Have you been told you grind your teeth during the night?	☐ Yes ☐ No

MEDICAL HISTORY

Please list other medical problems (such as high blood pressure, headaches, diabetes, etc.) and the doctor who handles each specific problem.

Problem	Physician

PREVIOUS SURGERIES

BED PARTNER QUESTIONNAIRE

1. Name and Relationship to Patient:

2. Check any of the behaviors you have observed this person doing while asleep.

☐ Biting Tongue	☐ Light Snoring	☐ Choking	☐ Loud Snorts
☐ Crying out	☐ Loud Snoring	☐ Pauses in Breathing	☐ Sleepwalking
☐ Twitching/Kicking Legs	☐ Grinding Teeth	☐ Twitching/Jerking Arms	☐ Becoming rigid/shaking
☐ Awakening in pain	☐ Sitting up while sleep	☐ Bed Wetting	☐ Getting out of bed not awake

☐ Other:

3. Please describe the sleep behaviors you have observed in detail. Include a description of the activity, when it occurs during the night, how often and whether or not it happens every night.

4. Has this person ever fallen asleep during normal activities or in dangerous situations? ☐ Yes ☐ No
If yes, please explain:

5. Do you have concern's with this patient's:

☐ Breathing at night	☐ Sleepwalking/talking
☐ Restlessness during sleep	☐ Becoming rigid or shaking during sleep?
	☐ Other:

EPWORTH SLEEPINESS SCALE	
How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate answer for each of the following. 0=WOULD NEVER DOZE 1=SLIGHT CHANCE OF DOZING 2=MODERATE CHANCE OF DOZING 3=HIGH CHANCE OF DOZING	
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (theatre, meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when able	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
TOTAL	

Patient Signature Date