Advanced
Ear, Nose, & Throat Associates, PC
Atlanta, Georgia

SLEEP DISORDER QUESTIONNAIRE

Name: _____ Date: _____ Chart No. _____

In order to better understand your sleep problem, please answer the following questions. If available, please ask your bed partner or observer for their input. Please make only one answer for each question. Where appropriate, write in the single best answer that applies. Answer "Yes" or "No" questions by clicking or marking the correct box.

CHIEF COMPLAINT:

Who referred you to see me? _____

Who is your primary physician? _____

What are the main problems that you are here for _____

_____

At approximately what age did your sleep problem begin? …….. _____ years old

Have you had an evaluation for this problem? ……... ☐ Yes ☐ No

Have you been treated (or tried any treatment) for this problem? ….. ☐ Yes ☐ No

If yes, what treatments? _____

Have you had a sleep study? ……. ☐ Yes ☐ No

If yes, when and where? _____

HISTORY OF PRESENT PROBLEM:

	Work Day	**Weekends**
When do you usually go to bed?	____ am ____ pm	____ am ____ pm
When do you usually get up?	____ am ____ pm	____ am ____ pm
How long does it take you to fall asleep at night?	____ minutes	____ minutes
On average, how long do you sleep each night?	____ hours	____ hours
How many times do you wake up during the night?	____ times	____ times
Do you use a snooze alarm?	☐ Yes ☐ No	☐ Yes ☐ No
Do you return to bed after arising?	☐ Yes ☐ No	☐ Yes ☐ No
How do you awaken at the end of your sleep period?	☐ spontaneously	☐ spontaneously
	☐ alarm clock	☐ alarm clock
	☐ other	☐ other

What do you ordinarily do (e.g. reading, T.V., bath) just prior to turning out the lights and attempting to go to sleep?

_____

Do you take naps? …….. ☐ Yes ☐ No

If yes, about how many times per week? _____ times

What is your present weight? _____ lbs. height:_____ neck size:_____ inches

Has your weight changed in the last five year? ☐ Yes ☐ No

If your weight has increased, by how many pounds? _____ lbs

If your weight has decreased, by how many pounds? _____ lbs

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Please check for each symptom.

My family complains about my snoring ……	☐ Yes	☐ No
People refuse to share a bedroom because of my snoring ……	☐ Yes	☐ No
Loud snoring when sleeping on my back……....	☐ Yes	☐ No
Loud snoring when sleeping on my side……..	☐ Yes	☐ No
I have been told I stop breathing during sleep……...	☐ Yes	☐ No
I have been told I choke or gasp during sleep……	☐ Yes	☐ No
I wake up with a choking or gasping sensation……..	☐ Yes	☐ No
I wake up with my heart beating faster than usual……	☐ Yes	☐ No
I wake up feeling frightened……...	☐ Yes	☐ No
I wake up frequently during the night…….....	☐ Yes	☐ No
Unusual movements while asleep……	☐ Yes	☐ No
Profuse sweating during the night……	☐ Yes	☐ No
Nasal congestion, obstruction or discharge at night……	☐ Yes	☐ No
Dry mouth upon awakening…….....	☐ Yes	☐ No
Headaches upon awakening……	☐ Yes	☐ No
Waking up feeling tired……	☐ Yes	☐ No
Feeling exhausted despite sleeping for many hours……..	☐ Yes	☐ No
Unable to get good quality sleep……...	☐ Yes	☐ No
Fighting sleepiness during daily activities…….....	☐ Yes	☐ No
Difficulty staying alert when I am required to……..	☐ Yes	☐ No
Falling asleep at the wrong times……..	☐ Yes	☐ No
Decreased concentration…….....	☐ Yes	☐ No
Forgetfulness…….....	☐ Yes	☐ No
Difficulty getting to sleep……..……	☐ Yes	☐ No
Taking more than 30 minutes to fall asleep on most nights……..…	☐ Yes	☐ No
Waking up during the night and having a hard time falling back to sleep……	☐ Yes	☐ No
Waking up early and being unable to fall back asleep……...	☐ Yes	☐ No
Need to use sleeping pills……...	☐ Yes	☐ No
Unable to sleep at all……..….	☐ Yes	☐ No
Getting 3-4 hours of sleep on most nights……	☐ Yes	☐ No
Difficulty sleeping away from home……..	☐ Yes	☐ No
Creeping crawling sensation of legs before sleep……..	☐ Yes	☐ No
Restlessness of legs when lying down in bed before sleep……	☐ Yes	☐ No
Leg twitches during sleep……	☐ Yes	☐ No
Waking up feeling paralyzed and unable to move……..……	☐ Yes	☐ No
Sudden body weakness brought by strong emotions……	☐ Yes	☐ No
Sudden buckling of the knees brought by strong emotions…… ……	☐ Yes	☐ No
Seeing things when trying to sleep……..……	☐ Yes	☐ No
Hearing voices or noises when going to sleep……	☐ Yes	☐ No
Talking while asleep……	☐ Yes	☐ No
Walking while asleep……..……	☐ Yes	☐ No
Eating during the night…… ……....	☐ Yes	☐ No
Grinding teeth while asleep……..……	☐ Yes	☐ No
I often recall my dreams ……..……	☐ Yes	☐ No
Disturbing dreams ……..……	☐ Yes	☐ No

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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. Use the following scale and **CHECK** the most appropriate **number** for each situation:

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 ……..	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV ……..	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (e.g. a theater or a meeting) ……	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break ……..	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit…	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone ……	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol ……..	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic ……..	☐ 0	☐ 1	☐ 2	☐ 3

Total_____

Have you been in a car accident due to falling asleep at the wheel?	☐ Yes	☐ No
Have you had a near miss due to falling asleep at the wheel? ……	☐ Yes	☐ No
Are you bothered by periods of depression?	☐ Yes	☐ No
Does every little thing get on your nerves?	☐ Yes	☐ No
Do you become suddenly anxious for no good reason? ……	☐ Yes	☐ No
Has your shoe size changed recently? ……	☐ Yes	☐ No
Has your hand or ring size changed recently? ……	☐ Yes	☐ No
Do you experience painful or stiff joints?	☐ Yes	☐ No
Do you suffer from constipation? ……	☐ Yes	☐ No
Do you feel cold all the time? ……	☐ Yes	☐ No
Do you have problems with very dry skin? ……	☐ Yes	☐ No
Do you suffer from indigestion? ……	☐ Yes	☐ No
Do you awaken with an acid taste in your mouth or throat? ……	☐ Yes	☐ No
Are you troubled by constant coughing?	☐ Yes	☐ No
Do you have to clear your throat frequently? ……	☐ Yes	☐ No
Do you have hay fever (allergies)? ……	☐ Yes	☐ No
Do you have problems with itchy nose, runny nose, or itchy eyes? ……	☐ Yes	☐ No
Do you have difficulty breathing through your nose? ……	☐ Yes	☐ No

If yes, which side is more difficult? ☐ Right ☐ Left ☐ Same

Is it worse during the day or night? ☐ Day ☐ Night ☐ Same

If it is worse during any season, when is it more difficult? _____

Your Occupation: _____

What are your usual working hours? Start: _____ Stop: _____

Are you currently Married, Single, Widowed, or Divorced? _____

Do you have a regular bed partner or observer of your sleep? ☐ Yes ☐ No

Reviewed and accepted into patient history: _____ Date: _____