



Sleep Study Questionnaire

Baptist Health Sleep Disorders Centers

Baptist Downtown
Pavilion, 7th Floor
800 Prudential Dr.
Jacksonville, FL 32207

Baptist Beaches
Wilson/Epstein Center
1320 Roberts Dr.
Jacksonville Beach, FL 32250

Baptist Nassau
1864 Lime Street
Suite #1
Fernandina Beach, FL 32034

Baptist South
14546 Old St Augustine Rd.
Suite #205
Jacksonville, FL 32258

DEMOGRAPHIC INFORMATION:

Patient's name: _____ Date of birth: _____
Last First MI

Home address: _____
Street City State Zip Code

Home phone: _____ Work: _____ Cell: _____

Sex: _____ Age: _____ Height: _____ Weight: _____ lbs. Neck size: _____

Name of physician ordering sleep study: _____

Referring physician's address: _____

Referring physician's phone number: _____ Fax number: _____

Check either "yes" or "no" for the following questions:

| | Yes | No |
|--|-------|-------|
| I nsomnia | _____ | _____ |
| S noring | _____ | _____ |
| N ot breathing / nocturnal choking | _____ | _____ |
| O besity | _____ | _____ |
| R estorative sleep | _____ | _____ |
| E xcessive daytime sleepiness | _____ | _____ |
| D rugs / alcohol / prescribed narcotics and sedatives | _____ | _____ |

Please respond to the following questions to the best of your ability. If you have a bed partner, please have him/her answer the questions about YOUR sleeping habits.

| | Patient's Response | Partner's Response |
|--|--------------------|--------------------|
| 1. How long have you had a problem with your sleep? | _____ | _____ |
| 2. How many nights per week do you have sleeping problems? | _____ | _____ |
| 3. How many hours do you sleep a night? | _____ | _____ |
| 4. How many times do you awaken at night? | _____ | _____ |
| 5. How long are you awake on average? | _____ | _____ |
| 6. How long does it take you to fall asleep? | _____ | _____ |
| 7. Do you have leg pain when trying to fall asleep? | _____ | _____ |
| 8. Does your leg pain (aching, cramping, sensation that you have to move your legs) awaken you during the night or prior to sleep? | _____ | _____ |
| 9. Do you have any unusual sleep habits? | _____ | _____ |
| If yes, please describe: _____ | | |
| 10. Are you currently a shift worker? | _____ | _____ |
| If yes, please describe your occupation: _____ | | |

How many ounces of the following beverages or foods do you consume daily?

Coffee:_____ Caffeinated soft drinks:_____ Tea:_____ Alcoholic beverages:_____ Chocolate:_____

Please rate yourself during the following situations using the scale below (1-5):

- 1 – No problem, never occurs
- 2 – Mild problem, rarely occurs
- 3 – Moderate problem, happens occasionally
- 4 – Moderately severe problem, occurs often
- 5 – Severe problem, occurs regularly

Rate how the following situations affect your sleep:

- _____ Sleeping in an unfamiliar bed?
- _____ Asthma?
- _____ Coughing?
- _____ Difficulty breathing while lying flat?
- _____ Reflux / regurgitation? (burning in the throat)
- _____ Frequent need to urinate?
- _____ Nasal congestion?
- _____ Pain in your legs?

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Rate the difficulty you have with the following:

- _____ Daytime sleepiness, dozing off or struggling to stay awake?
- _____ Fatigue or exhaustion during the day?
- _____ Snoring?
- _____ Falling asleep at inappropriate times during the day?
- _____ Work/studies compromised because of fatigue or sleepiness?
- _____ Falling asleep while operating a motor vehicle?
- _____ Accidents as a result of falling asleep while driving?
- _____ Feeling sleepy / fatigued?
- _____ Feelings of weakness after a surprise or emotional change?
- _____ Daytime hallucinations or dreaming?
- _____ Not being able to move when first waking up, despite the feeling of being awake?
- _____ Holding your breath, stopping breathing or making gasping sounds when sleeping?
- _____ Gasping for air or feeling unable to breath when waking?

Please place an "X" by any of the following that apply to you:

- | | | |
|-----------------------|-------------------------|---------------------------------|
| _____ Nightmares | _____ Palpitations | _____ Feelings of panic |
| _____ Unable to relax | _____ Bowel disturbance | _____ Fainting |
| _____ Headaches | _____ Dizziness | _____ Tense feelings |
| _____ Poor memory | _____ Depression | _____ Difficulty with decisions |
| _____ Shyness | _____ Insomnia | _____ Suicidal thoughts |
| _____ Anxiety | _____ Stomach problems | |

Do you have any other issues that interrupt your sleep? _____

Is there any additional information pertinent to your sleep evaluation that you feel is important to explain?

Do you currently use home oxygen? _____

If yes, how many hours a day? _____ Daytime? _____ Nighttime? _____

Medical History

Please list any chronic medical illnesses diagnosed by a physician that you have (i.e. diabetes, hypertension, incontinence, etc.) _____

Medications (prescription and over-the-counter)

| <i>Medication</i> | <i>Purpose</i> | <i>Time of day</i> | <i>Dosage</i> |
|-------------------|----------------|--------------------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Signature: _____

Relationship to patient: _____

Below to be completed by Sleep Center physician or designee

Questionnaire review by: _____ Date: _____

Test to be performed: _____

Special instructions: _____
