The Portland Clinic

AASM ACCREDITED Facility Member™

Sleep Disorder Questionnaire

Name: ______________________________________ Date: ___________________

Date of Birth: _____________________ Gender: _________________

Marital Status: ____Married ____Never Married ____Divorced ____Widowed

Referring Provider: ____

SYMPTOMS			
Snoring?	____Yes	____No	If yes, how long:
Breathing stops during the night?	____Yes	____No	If yes, how long:
Difficulty falling asleep?	____Yes	____No	If yes, how long:
Difficulty staying asleep at night?	____Yes	____No	If yes, how long:
Sleepiness or feeling tired?	____Yes	____No	If yes, how long:
Bed partner making you seek help?	____Yes	____No	
Other:			

EPWORTH SLEEPINESS SCALE: How likely are you to "doze off" or fall asleep in the situations described below? Select the best answer:

0= Would never doze 1= Slight chance 2= Moderate chance 3= High chance

	0	1	2	3
Sitting and reading				
Watching television				
Sitting inactive in a public place – for example, 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 to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Clinic Use Only - Total Epworth Sleepiness Score: ____________

What treatment have you tried to improve your sleep and was it helpful?

____

SLEEP- WAKE SCHEDULE

What are your work hours: ______________________________

What is your current occupation / job title? ______________________________

Do you drink alcohol 1 – 4 hours before going to bed? ________________________

Do you keep a fairly regular sleep schedule? ______________________________

Weekdays – normal wake time ____________AM - Normal bedtime ________PM

Weekends – normal wake time ____________AM - Normal bedtime ________PM

Once in bed, how long does it take to fall asleep? ________________

Once asleep, how many times do you wake up? _________________

What causes you to wake up? _______________________________

Do you get up multiple times to go to the bathroom? _____________

Total number of hours of sleep _____________

Do you awaken refreshed? ____Always ____Sometimes ____Never

How often do you take naps? (Please select one)

____ Daily ____ A few days a week ____A few days a month ____Rarely/never

If you nap, how long are your naps? ___________________________

SLEEP ENVIRONMENT

	Yes	**No**
Do you usually sleep in the same bed every night?		
Do you watch TV, read in bed or use a computer/phone before sleep?		
Does your partner often disrupt your sleep?		
Is your bed comfortable?		

SLEEP SYMPTOMS

	Always	Sometimes	Never
Difficulty falling sleep			
Trouble staying asleep			
Repeated awakenings			
Waking up too early			
Snoring or difficulty breathing			
Choking or gasping			
Morning headaches			
Dry Mouth			
Tired or crampy legs when you awaken			
Leg, arm, or body jerks			
Unpleasant feelings in arms or legs when you awaken			
Irresistible desire to move legs			
Intense visual images when falling asleep			
Sleep talking			
Sleep walking			
Rapid heart beat			
Heartburn			
Other behaviors - please list			

AWAKENING SYMPTOMS

	Always	Sometimes	Never
Anxious or panicky feeling			
Legs, arms or body moving or jerking			
Bed covers extremely messy			
Vivid or frightening images			
Temporarily unable to move your body			
Momentary confusion			

DAYTIME SYMPTOMS

	Always	Sometimes	Never
Feeling tired or sleepy during the day			
Struggling to stay awake			
Often feel "brain fog" or in a daze			
Feeling sleepy while driving			
Falling asleep in mid-conversation			
Falling asleep during normal daytime activities			
Falling asleep during dangerous situations (i.e. driving)			
Trouble focusing on work			
Difficulty remembering			
Sudden muscular weakness with strong emotion			
Muscle weakness during intense emotion			
Feeling sad, depressed, anxious or irritable			

REVIEW OF SYMPTOMS (PLEASE CHECK ALL THAT APPLY)

	Weight gain		Shortness of breath		Feeling depressed
	Coughing		Urinary frequency		Feeling anxious
	Wheezing		Erectile dysfunction		Heartburn
	Chest pain		Pain in muscles		Ankles swelling
	Palpitations		Pain in joints		Abdomen discomfort

PERSONAL MEDICAL HISTORY – (PLEASE CHECK ALL THAT APPLY)

	Hypertension		Diabetes		Cardiac Arrythmias
	Stroke		Dementia		Myocardial Infarction (heart attack)

MEDICATIONS: (Do not need to fill out if current patient at The Portland Clinic.)
Please list medication name and dosage.

____

____

ALLERGIES: ____

CAFFEINATED BEVERAGES (including coffee, tea, sodas, etc.): Please list type, amount, and frequency – i.e. 1 cup of coffee per day.

____

ALCOHOL: Please list type, amount, and frequency – i.e. 2 glasses of wine 2 nights per week.

____

TOBACCO or MARIJUANA: Please list type, amount, and frequency – i.e. 1 pack of cigarettes per day.

____

FAMILY HISTORY OF SLEEP DISORDERS

	Problem	**Relationship to patient**
	Insomnia	
	Daytime sleepiness	
	Restless leg syndrome	
	Narcolepsy	
	Sleep apnea	
	Habitual snoring	

BED PARTNER QUESTIONS:

Do you have a regular bed partner? _____Yes _____No

If possible, please have your bed partner (or anyone who observed you sleep recently) help answer the questions below.

When asleep, do others observe:	**Always**	**Sometimes**	**Never**
Snoring			
Loud breathing or sighing			
Breathing becomes labored			
Long pauses between breaths			
Repeated moving of arms, legs, or body			
Teeth grinding			
Sleep walking			
Sleep talking			
Acting out dreams			

Do any of the above result in sleeping in separate beds? ____Yes ____No

Use the space below to have your bed partner describe any additional information, concerns, or problems they feel should be included for evaluation:

____

____