The Christ Hospital Health Network

This questionnaire may not seem to pertain to your specific complaint; still answer them as best you can. The questionnaire is a broad based screening tool that is very helpful. Please consult family members or sleep partners on some questions.

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Preferred Name: _____

Height: _____ft. _____in. Weight: _____lbs. Shirt Collar Size: _____

Referring Physician: _____

A. SLEEP HISTORY (may elaborate in space provided at the end of this section)

How long have you had poor quality sleep?_____ years

Are you sleepy during the day?_____ If yes, for how long?_____ years

Does your bed partner complain about your snoring? _____ If yes, for how long? _____ years

Does your bed partner notice you stop breathing at night?_____If yes, for how long?_____years

Do you wake up at night with gasping /wake up from your snoring?_____

How many hours of sleep do you estimate you get at night?_____ hours

Have you been diagnosed with or treated for sleep apnea before? ☐ Yes ☐ No

B. SLEEP HABITS

1. What time do you go to bed on weekdays? _____AM/PM On weekends? _____AM/PM
2. What time do you wake up on weekdays? _____AM/PM On weekends? _____AM/PM
3. When you go to bed, how long does it usually take to fall asleep? _____ Minutes
4. When awakenings occur, are they associated with need to urinate? ☐ Yes ☐ No

   If yes, how many times you wake up to urinate during the night? _____
5. Do you take naps during the day? ☐ Yes ☐ No

   If yes, how many naps?_____
6. Do you feel that you suffer from insomnia? (difficulty falling or maintaining asleep)
   Yes ☐ No ☐
7. If yes, are you on any treatment for insomnia? Include any over the counter medications. _____
8. Do you have problems falling asleep OR maintaining asleep? Please describe_____

C. OTHER SLEEP RELATED PROBLEMS:

1. Do you have restless leg symptoms (urge to move your legs)? ☐ Yes ☐ No
   Are your restless leg symptoms worse during rest, like lying in bed? ☐ Yes ☐ No
   Are your restless leg symptoms better when you get up and walk? ☐ Yes ☐ No
   Are your restless leg symptoms worse during the evenings? ☐ Yes ☐ No

2. Do you have frequent early morning headaches? ☐ Yes ☐ No

3. Do you experience frequent nightmares? ☐ Yes ☐ No

4. Have you ever awoken from sleep with a feeling of muscular paralysis? ☐ Yes ☐ No

5. Have you ever developed muscular paralysis during wakefulness (particularly with periods of laughter or excitement)? ☐ Yes ☐ No

6. Have you ever been involved in an automobile accident related to your drowsiness? ☐ Yes ☐ No

D. OTHER MEDICAL PROBLEMS:

1. Are you suffering from any cardiac (heart) problems? ☐ Yes ☐ No
   If yes, please describe _____

2. Are you suffering from any pulmonary (lung) problems? ☐ Yes ☐ No
   If yes, please describe _____

3. Are you suffering from any allergy /sinus problems? ☐ Yes ☐ No
   If yes, please describe _____

4. Are you suffering from any Hypertension (blood pressure) problems? ☐ Yes ☐ No
   If yes, are you on treatment? _____

5. Are you suffering from any depression or mood disorders? ☐ Yes ☐ No
   If yes, are you on treatment? _____

E. SURGICAL HISTORY:

1. Have you had a tonsillectomy? ☐ Yes ☐ No If yes, when? _____
2. Have you had any sinus or nasal surgery? ☐ Yes ☐ No If yes, when?_____
3. Have you had any surgeries for snoring or sleep apnea? ☐ Yes ☐ No If yes, when? _____

F. PERSONAL HISTORY:

1. On average, how many caffeinated beverages do you consume per day? _____
2. Do you smoke? ☐ Yes ☐ No If yes, how many packs for how many years? _____
3. Were you a former smoker? ☐ Yes ☐ No If yes, how long did you smoke and when did you quit? _____
4. Do you drink alcohol prior to bedtime frequently? ☐ Yes ☐ No
5. Are you required to do shift work? ☐ Yes ☐ No
6. Please describe your work and work schedule _____

G. DIET AND EXERCISE HISTORY:

1. Have you tried any diet / weight loss therapy before? ☐ Yes ☐ No
   Explain diets you tried/for how long? _____
2. Do you exercise regularly? ☐ Yes ☐ No
   Explain your exercise habits _____
3. Have you had any recent change in body weight? ☐ Yes ☐ No
   Gained _____ lbs. Lost _____ lbs. Over how long? _____ years

H. FAMILY HISTORY:

1. Has anyone in your family had sleep apnea? ☐ Yes ☐ No

I. MEDICATION HISTORY:

PLEASE LIST ALL THE MEDICATIONS YOU TAKE INCLUDING THE DOSE AND HOW MANY TIMES A DAY: (ATTACH A SEPARATE SHEET IF NECESSARY)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not done some of these things, try to work out how these situations would affect you. Use the following scale:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	*chance of dozing*
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total	_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	◯ 0	◯ 1	◯ 2	◯ 3
2. Feeling down, depressed, or hopeless	◯ 0	◯ 1	◯ 2	◯ 3
3. Trouble falling or staying asleep, or sleeping too much	◯ 0	◯ 1	◯ 2	◯ 3
4. Feeling tired or having little energy	◯ 0	◯ 1	◯ 2	◯ 3
5. Poor appetite or overeating	◯ 0	◯ 1	◯ 2	◯ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	◯ 0	◯ 1	◯ 2	◯ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯ 0	◯ 1	◯ 2	◯ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	◯ 0	◯ 1	◯ 2	◯ 3
9. Thoughts that you would be better off dead, or of hurting yourself	◯ 0	◯ 1	◯ 2	◯ 3
add columns		+	+	
TOTAL				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

FATIGUE SEVERITY SCALE (FSS)

It is important that you circle a number (1 to 7) for each question.

During the past week, I have found that:	Disagree ← → Agree						
1. My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. Exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. My fatigue prevents sustained physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7. Fatigue interferes with carrying out certain duties and responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8. Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9. Fatigue interferes with my work, family or social life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**