

Sleep Medicine Questionnaire – New Patient

NAME: _____

DATE: _____

Do you keep a regular sleep/wake schedule? _____

Weeknights:

Bedtime: _____ PM

Wake time: _____ AM

Weekends:

Bedtime: _____ PM

Wake time: _____ AM

How long does it take you to fall asleep? _____

What is your preferred sleeping position? _____ (back/side)

After falling asleep, how many time(s) per night do you wake up? _____

Do you snore? _____

Do you stop breathing during sleep? _____

Do you wake up from sleep gasping for air or choking? _____

Do you feel refreshed upon waking up? _____

Do you wake up with a dry mouth in the morning? _____

During sleep, do you usually breathe through your mouth or nose? _____

Recent change in weight? _____

Do you feel sleepy during the day? _____ If yes, for how long have you felt sleepy during the day? _____

Do you take daytime naps? _____ If yes, how many times/week? _____
How long does your nap last? _____ mins. Are these daytime naps refreshing? _____

Do you feel drowsy while driving? _____ Have you ever fallen asleep while driving? _____ Have you ever had a motor vehicle accident due to sleep related issues? _____

Do you drink caffeinated beverages? _____ If yes, what do you drink? _____
How much? _____

Have you had any nasal fracture or other facial trauma? _____

Have you had any upper airway surgery? (i.e., tonsillectomy, adenoidectomy, tracheostomy, etc.) _____

Do you have any reflux or heartburn during night? _____

Do you have any difficulty with memory or concentration? _____

Have you had any prior sleep studies? _____

Past treatments for any sleep disorders. _____

Name: _____ Date: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? 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 to choose 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**

<u>Situation</u>	<u>Chance of Dozing</u>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place, for example, 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 with no alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Neck Size: _____

Total: _____

Name: _____ Date: _____

STOP BANG Sleep Apnea Questionnaire

STOP		
Do you S nore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel O ften feel Tired, fatigued, or sleepy during daytime?	Yes	No
Has anyone B Observed you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood A Pressure?	Yes	No

BANG		
B MI more than 35 kg/m ²	Yes	No
A GE over 50 years old?	Yes	No
N ECK circumference > 16 inches (40 cm)?	Yes	No
G ENDER: Male?	Yes	No

TOTAL SCORE		