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PULMONARY AND SLEEP SPECIALISTS

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? _____

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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. _____

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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

Situation	Chance of Dozing
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:_____

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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 **T**ired, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**bserved you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**ressure?	Yes	No

BANG		
BMI more than 35 kg/m2	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40 cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		