Clear Lake Sleep Center
501 Orchard, Suite 100
Webster, TX 77598
PH: 281-557-3557

SLEEP DISORDERS QUESTIONNAIRE

Date: _____

Name: _____ Date of Birth: _____

Sex: _____ Height: _____ Weight: _____ Referring physician: _____

1. What is your primary sleep problem? _____
_____

2. Who initially suspected a sleep problem? _____

3. Do you currently have a bed partner/roommate? _____
If yes, please have them assist you with this questionnaire.

4. Have you been seen by a sleep specialist before? _____

5. Have you had difficulty at work/school due to your sleep problem? _____

6. Have you had difficulty driving due to your sleep problems? _____

7. What is your primary work shift? _____

8. How many caffeinated drinks do you have daily? _____

9. If you snore, please rate the noise level:

4	3	2	1
heard outside room	wakes bed partner	easily heard	barely noticeable

10. Do you take naps during the day? _____Yes _____No

11. Have you ever smoked cigarettes? _____Yes _____No
How many packs per day? _____
How many years did you smoke? _____
Have you quit smoking yet? _____Yes _____No

12. Has anyone ever observed you stop breathing when you sleep? _____Yes _____No

13. Do you awaken gasping or choking? _____Yes _____No

14. Do you have trouble falling asleep? _____Yes _____No

15. Do you kick or twitch your legs when you sleep? _____Yes _____No

Clear Lake Sleep Center
501 Orchard, Suite 100
Webster, TX 77598
PH: 281-557-3557

16. How many times do you awaken during the night? _____

17. How many times do you get up to urinate at night? _____

18. Do you have creepy/crawly feelings, numbness of legs, when you are trying to fall Asleep? _____Yes _____No

19. Have you ever used diet pills? _____Yes _____No

20. Have you ever used stimulant drugs before? _____Yes _____No
    Have you ever used marijuana? _____Yes _____No
    Have you ever used cocaine or other drugs? _____Yes _____No

21. Do you sit up and scream while asleep or suddenly wake up scared? _____Yes _____No

22. Do you walk while asleep, with no recall the next day? _____Yes _____No

23. Do you have frightening nightmare or dreams? _____Yes _____No

24. Have you felt paralyzed, unable to move, but mentally alert while falling asleep or awakening? _____Yes _____No

25. Have you had a sudden physical weakness of arms, legs, or face when laughing? crying or during other emotional situations? _____Yes _____No

26. Do you have palpitations or chest pain at night? _____Yes _____No

27. How much alcohol do you consume within three hours of bedtime? _____
    How much alcohol do you consume within a 24-hour period? _____

28. Please explain strange feelings or behavior you have or had during the night.

_____

_____

29. Please list any medication you are currently taking:
    (Include sleeping pill or Melatonin)

_____ _____ _____

_____ _____ _____

Clear Lake Sleep Center
501 Orchard, Suite 100
Webster, TX 77598
PH: 281-557-3557

30. Have you now or in the past experienced any health problems in the following areas?

High blood pressure	_____	Shortness of breath	_____
Deviated nasal septum	_____	Chronic cough	_____
Sinus problems	_____	Asthma	_____
Tonsillectomy	_____	Emphysema	_____
Heart Disease	_____	Thyroid Disease	_____
Psychiatric	_____	Diabetes	_____
Heartburn	_____	Reflux	_____

Please list any other medical problems you have or have had:

_____

_____

_____

31. Sleepiness scale

Please use this scale to evaluate the following questions:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

1. Sitting and reading _____
2. Watching T.V. _____
3. Sitting inactive in a public gathering _____
4. As a passenger in a car for an hour without break _____
5. Lying down in the afternoon circumstances permitting _____
6. Sitting and talking to someone _____
7. Sitting quietly after lunch not having consumed alcohol _____
8. Driving a car that has stopped briefly at a red light _____

Total Epworth Score _____

Epworth Sleepiness Score (ESS) by Diagnosis
0-9 = Normal 10-13 = Mild 14-19 = Moderate 20-23 = Severe
If your results are greater than 9 and/or you feel you may have sleep apnea, print this quiz and take it to your physician. You are also welcome to call us if you have further questions or concerns.