- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Heatlh Clinics

SLEEP DISORDERS CENTER ADULT PATIENT QUESTIONNAIRE

(Patient Label Here)

Thank you for helping us to take better care of you! Please complete the following:

Name:______________________________ Date of Birth: ____________________

Patient's Preferred Language: ______________________________

Home Address: ______________________________

Home Phone: ____________________ Other Phone: ____________________

Height: __________ Weight: __________ Referring MD: ____________________

Other MD's you would like us to communicate with: ______________________________

Please describe your sleep problem: ______________________________

____

How long ago did this problem begin? ______________________________

Please describe any previous evaluation or treatment for this problem (sleep study, CPAP, etc) ____________________

____

Question			
Do you snore?	q YES	q NO	
Do you stop breathing while you sleep?	q YES	q NO	
Have you ever gasped or choked awake from sleep?	q YES	q NO	
Do you feel rested when you wake up in the morning?	q YES	q NO	
Do you feel sleepy during the day?	q YES	q NO	
Have you gained weight in the last year?	q YES	q NO	If yes, how much? __________
Do you often have trouble falling asleep?	q YES	q NO	
Do you wake up frequently during the night?	q YES	q NO	
Do you routinely experience an abnormal sensation in your legs which prevents you from falling asleep, also known as "restless legs?"	q YES	q NO	
Have you ever experienced sudden body weakness brought on by laughter, surprise, or fear?	q YES	q NO	
Have you ever experienced seeing or hearing things that were not real when you were going to sleep or just waking up?	q YES	q NO	
Have you ever uncontrollably fallen asleep at an inappropriate time or place when you were trying hard to stay awake?	q YES	q NO	

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Have you ever woken up from sleep and your mind is awake but your body will not move? ☐ YES ☐ NO

What is your occupation? ______________________

Do you do shift work? ☐ YES ☐ NO If yes, please describe your schedule: ______________________

List your sleeping hours WORK DAYS: Go to bed ____________ a.m. /p.m. Get up ____________ a.m. /p.m.

List your sleeping hours NON WORK DAYS: Go to bed ____________ a.m. /p.m. Get up ____________ a.m./pm

Do you take any medications or herbal remedies to help you sleep? ☐ YES ☐ NO If yes, what are they and what time do you take them? ______________________

Do you take any medications to help you stay awake/alert? ☐ YES ☐ NO If yes, what are they and what time do you take them? ______________________

How long does it usually take you to fall asleep after turning out the lights? ____________ Minutes

Do you watch TV, read or use your phone in bed? ☐ YES ☐ NO

On average, how many times do you wake up during the night? ______________________

On average, how many times do you get out of the bed at night? ______________________

If you get up at night, what is the reason that wakes you up or gets you up? ______________________

How long does it take you to fall back asleep? ______________________

If you are unable to fall back asleep what do you do? ______________________

Do you wake up too early in the morning, unable to return to sleep? ☐ YES ☐ NO

How do you ordinarily awaken? ☐ Spontaneously ☐ Alarm clock ☐ Other ______________________

Do you nap? ☐ YES ☐ NO If yes, how many times a week? ___________ If so, for how long? ___________

If yes, do you find naps refreshing? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If yes, how many days of the week do you drink? ______________________

If you drink alcohol, on average how many alcoholic beverages do you drink on weekdays? ___________ drinks/day

If you drink alcohol, on average how many alcoholic beverages do you drink on weekends? ___________ drinks/day

Do you smoke? ☐ YES ☐ NO If yes, how many cigarettes, pipes, or cigars/day? ______________________

For each of the following, please indicate the average number that you drink each day and how late in the day you drink them:

Coffee ___________ cups / day Latest drink ___________

Tea ___________ cups / day Latest drink ___________

Caffeinated soft drinks (Pepsi, Coca Cola, and Mountain Dew) ___________ / day Latest drink ___________

Energy drinks ___________ / day Latest drink ___________

Please list any medical conditions which you have or have had in the past:

Please list any medications and dosages that you are currently taking:

Please list any significant family history, especially any sleep disorders:

Is there anything else you think we should know?

Patient Signature

Date

Provider Signature

Date / Time

Interpreter Name or ID #

In person or via Cyracom (circle one)

Please continue on next page

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Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the past few days. Circle the number beside your choice.

0 1 2 3	I do not feel sad I feel sad I am sad all the time and I can't snap out of it I am so sad or unhappy that I can't stand it	0 1 2 3	I have not lost interest in other people I am less interested in other people I have lost most of my interest in people I have lost all of my interest in people
0 1 2 3	I am not particularly discouraged about the future I feel discouraged about the future I feel I have nothing to look forward to I feel that the future is hopeless and that things cannot improve	0 1 2 3	I make decisions about as well as I ever could I put off making decisions more than I used to I have greater difficulty in making decisions I can't make decisions at all anymore
0 1 2 3	I do not feel like a failure I feel I have failed more than the average person. As I look back on my life I see a lot of failure I feet I am a complete failure as a person	0 1 2 3	I don't feel that I look any worse than I used to I am worried that I am looking old or unattractive I feel that there are permanent changes in my appearance that make me look unattractive I believe that I look ugly
0 1 2 3	I get as much satisfaction out of things as I used to I don't enjoy things the way I used to I don't get any real satisfaction out of anything anymore I am dissatisfied or bored with everything	0 1 2 3	I can work about as well as before It takes an extra effort to get starting at doing something I have to push myself very hard to do anything I can't do any work at all
0 1 2 3	I don't feel particularly guilty I feel guilty a good part of the time I feel quite guilty most of the time I feel guilty all of the time	0 1 2 3	I can sleep as well as usual I don't sleep as well as I used to I wake up 1-2 hours earlier than usual and find it hard to get back to sleep I wake up several hours earlier than I used to and cannot get back to sleep
0 1 2 3	I don't feel I am being punished I feel I may be punished I expect to be punished I feel I am being punished	0 1 2 3	I don't get more tired than usual I get tired more easily than I used to I get tired from doing almost anything I am too tired to do anything
0 1 2 3	I don't feel disappointed in myself I am disappointed in myself I am disgusted with myself I hate myself	0 1 2 3	My appetite is no worse than usual My appetite is not as good as it used to be My appetite is much worse now I have no appetite at all anymore
0 1 2 3	I don't feel I am any worse than anybody else I am critical of myself for my weakness or mistakes I blame myself all of the time for my faults I blame myself for everything bad that happens	0 1 2 3	I haven't lost much weight, if any, lately I have lost more than five pounds I have lost more than ten pounds I have lost more than fifteen pounds (Score 0 if you have been purposely losing weight)
0 1 2 3	I don't have any thoughts of killing myself I have thoughts of killing myself, but I would not carry them out I would like to kill myself I would kill myself if I had the chance	0 1 2 3	I am no more worried about my health than usual I am worried about physical problems such as aches and pains, upset stomach, or constipation I am very worried about physical problems, and it's hard to think of much else I am so worried about my physical problems that I cannot think about anything else

Continued on next page

0 1 2 3	I don't cry more than usual I cry more now than I used to I cry all the time now I used to be able to cry, but now I can't cry even though I want to	0 1 2 3	I have not noticed any recent change in my interest in sex I am less interested in sex than I used to be I am much less interested in sex now I have lost interest in sex completely
0 1 2 3	I am no more irritated by things than I ever am I am slightly more irritated now than usual I am quite annoyed or irritated a good deal of the time I feel irritated all of the time now		**TOTAL:** ________________

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation:

	Would Never Nod Off 0	Slight Chance of Nodding Off 1	Moderate Chance of Nodding Off 2	High Chance of Nodding Off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

TOTAL: ________________

Add up your points to get your total score. A total of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention.

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TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a gladd of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the Week	Type of Day-Work, School, Off, Vacation	Noon	1 PM	2	3	4	5	6 PM	7	8	9	10	11 PM	Midnight	1 AM	2	3	4	5	6 AM	7	8	9	10	11AM	
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