Saint Luke's Health System
Sleep Disorders Program
Clinical Polysomnogram Questionnaire

Name: ________________________________ Age: ______ Height: ___________
Address: ______________________________ Sex: ______ Weight: ___________
______________________________________ Race: ______
Home Phone: (   ) ____________________ Work/Cell Phone: (   )_____________________

Referring Physician: _________________________ Family Physician: ____________________________

How did you hear about the Sleep Disorders Center at Saint Luke's Hospital? ___________________________
____

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, you will need to circle one of the following where asked:

NIGHTLY **WEEKLY** **RARELY** **NEVER**

1. Please describe your sleep pattern as best you can: ____
____
____

2. What is the most you have ever weighed? ___________________
   What did you weigh 5 years ago? ___________________
   What did you weigh 1 year ago? ___________________

3. When did your sleep problem begin? (month and/or year) ___________________________

4. Have you ever had a sleep study before? (   ) YES (   ) NO
   If yes, where was the test performed and what were the results? ______________________________
   ____

5. Please list your current medications:

TYPE OF MED	DOSE/FREQUENCY	LAST TAKEN
________________________	________________________	_________________________
________________________	________________________	_________________________
________________________	________________________	_________________________
________________________	________________________	_________________________
________________________	________________________	_________________________
________________________	________________________	_________________________

List medication allergies: ____

6. My ideal amount of sleep is ______________ hours per night.

During the week I usually:			**During the weekend I usually:**		
Go to bed at:	__________	(TIME)	Go to bed at	__________	(TIME)
Get up at:	__________	(TIME)	Get up at:	__________	(TIME)
Sleep a total of:	__________	(HOURS)	Sleep a total of:	__________	(HOURS)

7. My bed or sleeping surface is a (   ) standard mattress (   ) waterbed (   ) futon (   ) other

8. My job requires shift work (   ) Yes (   ) No If yes, my hours are ______________________

9. I can sleep 12 hours or more at a time
NIGHTLY WEEKLY RARELY NEVER

10. It usually takes me ________________ minutes to fall asleep.

11. I usually wake up _______________ times during the night. Please explain what wakes you up:
____

12. I have difficulty going back to sleep once I wake up:
NIGHTLY WEEKLY RARELY NEVER

13. I snore:
NIGHTLY WEEKLY RARELY NEVER

14. My snoring started at age ___________ .

15. I snore in all sleeping positions. ( ) Yes ( ) No

16. My snoring has been described to me as: ( ) Mild ( ) Moderate ( ) Loud

17. I have problems with my nose or nasal breathing ( ) Yes ( ) No
If yes, please explain: ____
____

18. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:
NIGHTLY WEEKLY RARELY NEVER

19. I wake up with a headache.
NIGHTLY WEEKLY RARELY NEVER

20. I have been told that I toss and turn to an extreme amount.
NIGHTLY WEEKLY RARELY NEVER

21. I flail or kick while sleeping.
NIGHTLY WEEKLY RARELY NEVER

22. I sleep walk.
NIGHTLY WEEKLY RARELY NEVER

23. Immediately after falling asleep, I dream.
NIGHTLY WEEKLY RARELY NEVER

24. I have been told that I talk or scream in my sleep.
NIGHTLY WEEKLY RARELY NEVER

25. I ( ) HAVE or ( ) HAD a bed wetting problem.
NIGHTLY WEEKLY RARELY NEVER

26. I have been told that I grind my teeth in my sleep.
NIGHTLY WEEKLY RARELY NEVER

27. I wake with a sour or stomach acid taste in my mouth.
NIGHTLY WEEKLY RARELY NEVER

28. I eat my last meal of the day at _____________ o’clock.

29. I wake up with my heart beating irregularly.
NIGHTLY WEEKLY RARELY NEVER

30. I wake up at night with muscle or joint aches and pains.
NIGHTLY WEEKLY RARELY NEVER

31. I have the feeling of "Restless legs."
NIGHTLY WEEKLY RARELY NEVER

32. I am troubled by tingling or burning sensations in my legs.
NIGHTLY WEEKLY RARELY NEVER

33. I am disturbed by nightmares,
NIGHTLY WEEKLY RARELY NEVER

34. I feel like I cannot move after lying down before going to sleep.
NIGHTLY WEEKLY RARELY NEVER

35. I see or hear things that are not real when lying in bed, but not asleep.
NIGHTLY WEEKLY RARELY NEVER

36. After a typical nights' sleep, I feel stiff and achy.
NIGHTLY WEEKLY RARELY NEVER

37. After a typical nights' sleep, I feel: ( ) refreshed ( ) fairly rested ( ) somewhat tired ( ) very drowsy

38. I take naps. ( ) Yes ( ) No If yes, how many naps per day? ______ If no, is there a reason why you do not take naps? ( ) No need ( ) No time ( ) Work / social situation does not permit.

39. I fight sleep or fall asleep uncontrollably for short periods of time while sitting (e.g. at meetings, watching TV, at the movies, etc.)
DAILY WEEKLY RARELY NEVER

40. I fight sleep while driving.
DAILY WEEKLY RARELY NEVER

41. I have fallen asleep while driving a car.
DAILY WEEKLY RARELY NEVER

42. I dream during my naps.
DAILY WEEKLY RARELY NEVER

43. After my naps, I feel ( ) refreshed ( ) fairly rested ( ) somewhat tired ( ) very drowsy

44. I feel a sudden weakness in my knees, neck, jaw or arms when I get angry, sad, while laughing or emotional.
DAILY WEEKLY RARELY NEVER

45. I have episodes of doing strange things without realizing it or losing a period of time.
DAILY WEEKLY RARELY NEVER

46. Drowsiness is greater in the ( ) Morning ( ) Afternoon ( ) Evening

47. It seems that my mood, memory, or thought processes have changed. ( ) Yes ( ) No

48. Within the last year, depression, anxiety, or stress has interfered with my sleep. ( ) Yes ( ) No
If yes, please explain: ____
____

49. My sleep problem, in addition to those listed above, has resulted in: ________________________________
____

50. Do you exercise? ( ) Yes ( ) No If yes, what kind, time of day, and how often do you exercise?
____

51. Is there any history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring?
____
____

52. Please list any medications tried for improving sleep or staying awake.

DRUG	**DOSE**	**FREQUENCY**	**DATE STARTED**	**DATE ENDED**
__________	__________	__________	__________	__________
__________	__________	__________	__________	__________
__________	__________	__________	__________	__________

Do you or have you smoked? ( ) Yes ( ) No
If yes, how many years have (did) you smoke? ________________
How many cigarettes (cigars) per day? ________________
If you quit, how long ago? ________________

54. Do you drink caffeinated beverages? ( ) Yes ( ) No
If yes, how many cups or cans per day? ________________
My usual beverage is ( ) coffee ( ) tea ( ) soda

55. I consume alcohol ( ) Yes ( ) No
If yes, how often? ( ) Daily ( ) Weekly ( ) Monthly
I usually drink in the: ( ) Morning ( ) Afternoon ( ) Evening
My usual beverage is ____________________________

56. How many time in a month do you have a serving (meal) of TUNA OR OTHER NON-FRIED FISH? __________

57. Do you take fish oil (omega-3) supplements? ( ) Yes ( ) No
If yes, what is the brand name of the supplement and how many capsules do you take per day on average?
____

58. Do you take flaxseed oil supplements? ( ) Yes ( ) No
If yes, what are the brand names of the supplements and how many capsules do you take per day on average?
____

The Epworth Sleepiness Scale

How likely are you to doze 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 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	_______
Watching television	_______
Sitting, inactive in a public place (e.g. theater or meeting)	_______
As a passenger in a car for an hour without a break	_______
Lying down to rest in the afternoon when circumstances permit	_______
Sitting and talking quietly to someone	_______
Sitting quietly after lunch without alcohol	_______
In a car, while stopped for a few minutes in traffic	_______
TOTAL	_______

SIGNATURE DATE