BAPTIST HEALTH

Sleep Study Questionnaire

Sleep Study Questionnaire
Once you've scheduled your appointment, please complete the sleep study questionnaire and fax or mail to our main office. If you have any questions, please contact us during office hours at 904.202.1632.

Fax to:
904.202.4951

Mail to:
Sleep Disorder Center
836 Prudential Drive
Jacksonville, FL 32207

DEMOGRAPHIC INFORMATION:

Patient's name: _____ _____ _____ Date of birth: _____
Last First MI

Home address: _____
Street City State Zip Code

Home phone: _____ Work: _____ Cell: _____

Sex: _____ Age: _____ Height: _____ Weight: _____lbs. Neck size: _____ Claustrophobic _____

Name of physician ordering sleep study: _____

Referring physician's address: _____

Referring physician's phone number: _____ Fax number: _____

Check either "yes" or "no" for the following questions:

	Yes	No
Insomnia	_____	_____
Snoring	_____	_____
Not breathing / nocturnal choking	_____	_____
Obesity	_____	_____
Restorative sleep	_____	_____
Excessive daytime sleepiness	_____	_____
Drugs / alcohol / prescribed narcotics and sedatives	_____	_____

Please respond to the following questions to the best of your ability. If you have a bed partner, please have him/her answer the questions about YOUR sleeping habits.

	Patient's Response	Partner's Response
1. How long have you had a problem with your sleep?	_____	_____
2. How many nights per week do you have sleeping problems?	_____	_____
3. How many hours do you sleep a night?	_____	_____
4. How many times do you awaken at night?	_____	_____
5. How long are you awake on average?	_____	_____
6. How long does it take you to fall asleep?	_____	_____
7. Do you have leg pain when trying to fall asleep?	_____	_____
8. Does your leg pain (aching, cramping, sensation that you have to move your legs) awaken you during the night or prior to sleep?	_____	_____
9. Do you have any unusual sleep habits?	_____	_____
If yes, please describe: _____		
10. Are you currently a shift worker?	_____	_____
If yes, please describe your occupation: _____		

How many ounces of the following beverages or foods do you consume daily?

Coffee:_____ Caffeinated soft drinks:_____ Tea:_____ Alcoholic beverages:_____ Chocolate:_____

Please rate yourself during the following situations using the scale below (1-5):

1 – No problem, never occurs
2 – Mild problem, rarely occurs
3 – Moderate problem, happens occasionally
4 – Moderately severe problem, occurs often
5 – Severe problem, occurs regularly

Rate how the following situations affect your sleep:

_____ Sleeping in an unfamiliar bed?
_____ Asthma?
_____ Coughing?
_____ Difficulty breathing while lying flat?
_____ Reflux / regurgitation? (burning in the throat)
_____ Frequent need to urinate?
_____ Nasal congestion?
_____ Pain in your legs?

Please rate yourself during the following situations using the scale below (1-5):

1 – No problem, never occurs
2 – Mild problem, rarely occurs
3 – Moderate problem, happens occasionally
4 – Moderately severe problem, occurs often
5 – Severe problem, occurs regularly

Rate the difficulty you have with the following:

_____ Daytime sleepiness, dozing off or struggling to stay awake?

_____ Fatigue or exhaustion during the day?

_____ Snoring?

_____ Falling asleep at inappropriate times during the day?

_____ Work/studies compromised because of fatigue or sleepiness?

_____ Falling asleep while operating a motor vehicle?

_____ Accidents as a result of falling asleep while driving?

_____ Feeling sleepy / fatigued?

_____ Feelings of weakness after a surprise or emotional change?

_____ Daytime hallucinations or dreaming?

_____ Not being able to move when first waking up, despite the feeling of being awake?

_____ Holding your breath, stopping breathing or making gasping sounds when sleeping?

_____ Gasping for air or feeling unable to breath when waking?

Please place an "X" by any of the following that apply to you:

_____ Nightmares
_____ Unable to relax
_____ Headaches
_____ Poor memory
_____ Shyness
_____ Anxiety
_____ Palpitations
_____ Bowel disturbance
_____ Dizziness
_____ Depression
_____ Insomnia
_____ Stomach problems
_____ Feelings of panic
_____ Fainting
_____ Tense feelings
_____ Difficulty with decisions
_____ Suicidal thoughts

Do you have any other issues that interrupt your sleep? _____

_____

Is there any additional information pertinent to your sleep evaluation that you feel is important to explain?

_____

_____

Do you currently use home oxygen? _____

If yes, how many hours a day? _____ Daytime? _____ Nighttime? _____

Medical History

Please list any chronic medical illnesses diagnosed by a physician that you have (i.e. diabetes, hypertension, incontinence, etc.) _____

_____

_____

_____

Medications (prescription and over-the-counter)

Medication	*Purpose*	*Time of day*	*Dosage*

Patient Signature: _____

Below to be completed by Sleep Center physician or designee

Questionnaire review by: _____ *Date:* _____ *Time:* _____

Test to be performed: *RT*_____ *CPAP*_____ *SPLIT*_____ *MSLT*_____ *MWT*_____

Special instructions: _____

_____