Sutter Health
Palo Alto Medical Foundation

# Patient Sleep Wake Questionnaire

This questionnaire is for patients 13 years of age or older who have a **scheduled appointment** at the Sleep Center. It will take approximately 15 to 20 minutes to complete. The information you provide is very important and will assist the sleep specialist during the review of your sleep symptoms. This questionnaire has been compiled based on many years of accumulated experience in Sleep Medicine. The information will be treated with the utmost discretion and will not be used by any party other than Palo Alto Medical Foundation (PAMF). Please respond to all questions by checking the appropriate box or completing the free text sections. If you have a bed partner, a parent or guardian, or otherwise someone who is willing to and is able to comment on your sleep patterns or behaviors during sleep, please have them complete Section 11.

Patient Name

Scheduled Appointment Date

Sleep Specialist

Today's Date

DOB

Age

Sex

Height (inches)

Weight Now (lbs)

Weight 1 Year Ago

Weight 5 Years Ago

Marital Status

Number of Children

Was Referred By

Name of Doctor

Specific issues I want to discuss at my appointment (please, list in order of concern):

1. _____

2. _____

3. _____

# 1. Sleep Schedule

What time do you go to bed on **weekdays**? _____ ☐ a.m. ☐ p.m.

What time do you go to bed on **weekends**? _____ ☐ a.m. ☐ p.m.

What time do you get out of bed on **weekdays**? _____ ☐ a.m. ☐ p.m.

What time do you get out of bed on **weekends**? _____ ☐ a.m. ☐ p.m.

How much sleep do you get on an average night (hours)? _____

Are you a morning type, evening type, neither? _____

What would be your ideal bedtimes? (**from** (a.m./p.m.) **to** (a.m./p.m.)) _____

Do you nap? ☐ Yes ☐ No

How often do you nap? (number of times per week) _____

How long are the naps? (in minutes) _____

Do you awaken refreshed from the nap? ☐ Yes ☐ No

What are your usual work hours? _____

Are you a shift worker? ☐ Yes ☐ No

If **yes**, what kind of shift do you work (hours)? _____

What is (was) your occupation? _____

If **retired**, when? _____

# 2. Sleep History

Do you have difficulty falling asleep? ☐ Yes ☐ No

Do you have difficulty staying asleep? ☐ Yes ☐ No

Do you wake up too early and cannot get back to sleep? ☐ Yes ☐ No

Do you have thoughts racing through your mind that make it difficult to sleep? ☐ Yes ☐ No

How long does it take you to fall asleep at night (minutes)? _____

Do you read in bed? ☐ Yes ☐ No

Do you watch TV in bed? ☐ Yes ☐ No

Do you share the bed with anyone? ☐ Yes ☐ No

Does your partner have a sleep disorder? ☐ Yes ☐ No

Do you have pets sleep in the bedroom? ☐ Yes ☐ No

Is your bedroom comfortable? ☐ Yes ☐ No

If **yes**, please describe:

How many times do you wake up during the night? _____

How long does it take you to fall asleep again (minutes)? _____

Do you have unpleasant feelings of fear, anxiety, tension, or unhappiness waking you up? ☐ Yes ☐ No

Do you have feelings of muscle tension or tightness in your arms or chest? ☐ Yes ☐ No

Do you have pain or joint discomfort? ☐ Yes ☐ No

Do you have other problems waking you up? ☐ Yes ☐ No

If **yes**, please describe:

In the morning, do you wake up with an alarm, naturally, both: _____

In the morning, do you wake up feeling sleepy, groggy, refreshed, tired: _____

## 3. Abnormal Movements/Behaviors

Do you have or have you ever experienced:

An urge to move your legs, usually accompanied by uncomfortable and unpleasant sensations in the legs? ☐ Yes ☐ No

Discomfort in the legs that worsens during periods of rest or inactivity such as lying down or sitting? ☐ Yes ☐ No

Discomfort in the legs that is relieved by movement, like walking or stretching? ☐ Yes ☐ No

Discomfort that worsens during the nighttime? ☐ Yes ☐ No

Do you have leg cramps (charley horse)? ☐ Yes ☐ No

Do you kick or jerk your arms or legs during sleep? ☐ Yes ☐ No

Are your bed covers messy in the morning? ☐ Yes ☐ No

Do you kick, punch or poke your bed partner while asleep? ☐ Yes ☐ No

If **yes**, have you ever injured your bed partner or yourself? _____

Do you grind your teeth? ☐ Yes ☐ No

Do you wear a bite splint (mouth guard)? ☐ Yes ☐ No

Do you walk in your sleep? ☐ Yes ☐ No

If **yes**, when was the last time? _____

Do you talk in your sleep? ☐ Yes ☐ No

Do you have nightmares or night terrors? ☐ Yes ☐ No

If **yes**, please describe the behavior, including the time of night, and frequency:

Have you acted out your dreams? ☐ Yes ☐ No

Do you make rolling movements or bang your head at night? ☐ Yes ☐ No

Did you have sleep problems as a child? ☐ Yes ☐ No

If **yes**, please describe:

## 4. Daytime Sleepiness

Have you fallen asleep unexpectedly? ☐ Yes ☐ No

Have you ever had an accident or near-miss because you have fallen asleep while driving? ☐ Yes ☐ No

If **yes**, when? _____

Have you **ever** experienced sudden muscle weakness when you laugh, listen to a joke, are surprised or angry? ☐ Yes ☐ No

If **yes**, answer the questions below. If no, please skip to the next questions.

a) Can you hear? ☐ Yes ☐ No

b) Does your speech ever become slurred? ☐ Yes ☐ No

c) Is your head affected? ☐ Yes ☐ No

d) Is your whole body affected? ☐ Yes ☐ No

How long does the weakness usually last? _____

Have you experienced dreamlike images or sounds while falling asleep or waking up? ☐ Yes ☐ No

Have you experienced an inability to move while falling asleep or waking up? ☐ Yes ☐ No

## The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? 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

| | |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive in a public place (e.g. a theatre 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 to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |
| **TOTAL score out of 24** | 0 |

# 5. Snoring/Breathing History

Do you snore? _____

What is your preferred sleep position (% of the time in each)?

Back (% of sleep time) _____

Left Side (% of sleep time) _____

Right Side (% of sleep time) _____

Stomach (% of sleep time) _____

Does your sleep position affect your snoring? ☐ Yes ☐ No

Do you awaken with a snort, choking or gasping for air? ☐ Yes ☐ No

Do you awaken with a headache? ☐ Yes ☐ No

Has anyone noticed you stop breathing while asleep? ☐ Yes ☐ No

Do you awaken often to urinate during the night? ☐ Yes ☐ No

Do you awaken with acid or sour taste in your mouth? ☐ Yes ☐ No

Do you have difficulty breathing while on your back? ☐ Yes ☐ No

Do you avoid sharing a room because of snoring? ☐ Yes ☐ No

Do you sweat excessively during the night? ☐ Yes ☐ No

Do you awaken with a dry mouth or sore throat? ☐ Yes ☐ No

# 6. MEDICAL/SURGICAL HISTORY

Have you ever had a sleep study in the past? ☐ Yes ☐ No

If **yes**, when? _____

If **yes**, where? _____

Do you use CPAP or BiPAP at home? ☐ Yes ☐ No

If **yes**, what pressure setting? _____

Do you use oxygen at home? ☐ Yes ☐ No

If **yes**, what liter/flow setting? _____

Have you ever had tonsils or adenoids removed? ☐ Yes ☐ No

Have you ever had sinus or nasal surgery? ☐ Yes ☐ No

Have you ever broken your nose? ☐ Yes ☐ No

Have you ever had any type of head injury? ☐ Yes ☐ No

Have you ever had surgery to promote weight loss? ☐ Yes ☐ No

If **yes**, when? _____

Have you had dental surgery or orthodontics? ☐ Yes ☐ No

If **yes**, please describe:

Please check the appropriate box if you have a history of any of the following:

| | | |
|---|---|---|
| ☐ Hypertension | ☐ Congestive heart failure | ☐ Heart attack |
| ☐ Cardiac arrhythmias | ☐ Stroke/TIA | ☐ Thyroid disease |
| ☐ Lung problems/COPD/asthma | ☐ Pulmonary hypertension | ☐ Diabetes |
| ☐ Parkinson's | ☐ Anemia/iron deficiency | ☐ Heartburn/reflux |
| ☐ Arthritis | ☐ Sexual dysfunction/loss of libido | ☐ Fibromyalgia |
| ☐ Depression/anxiety | ☐ Seizures | ☐ Menopause |
| ☐ Frequent blood donations | ☐ Connective tissue disease (e.g. Lupus) | ☐ Cancer |
| ☐ Nasal allergies/congestion | ☐ End stage kidney disease/dialysis | ☐ Other |

If **other,** please specify:

# FAMILY HISTORY

Does any member of your family have any of the following?

Snoring or sleep apnea? ☐ Yes ☐ No

If **yes**, relationship _____

Narcolepsy? ☐ Yes ☐ No

If **yes**, relationship _____

Seizure disorder? ☐ Yes ☐ No

If **yes**, relationship _____

Depression? ☐ Yes ☐ No

If **yes**, relationship _____

Hypertension, heart disease, heart failure? ☐ Yes ☐ No

If **yes**, relationship _____

Stroke? ☐ Yes ☐ No

If **yes**, relationship _____

Diabetes? ☐ Yes ☐ No

If **yes**, relationship _____

# Allergies

Please list any known medication or environmental (pets, pollens, food, etc.) allergies.

# Medications

List current medications (name, dose, and number taken per day), include OTC and vitamin/herbal supplements…

# Social History

Do you use tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipe)? _____

If **yes**, packs per day? _____

If **yes**, when did you start? _____

If **yes — quit**, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks? _____ per (day, week) _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

If **yes**, how many cups (8 oz.) per day? _____

Do you use recreational drugs? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

This completes the patient portion of the questionnaire. If you have a bed partner, a parent or guardian, or otherwise someone who is willing to and is able to comment on your sleep patterns or behaviors during sleep please have them complete Section 11. Otherwise please skip to Section 12, Sleepiness and Driving.

# Bed Partner, Parent Observation Questionnaire

Do you live with the patient? ☐ Yes ☐ No

Do you sleep in the same room as the patient? ☐ Yes ☐ No

If no, is it because of his/her sleep behaviors (i.e. snores too loudly, acts out dreams, etc)? ☐ Yes ☐ No

Check any of the following behaviors that you have observed the patient doing while asleep.

| | | |
|---|---|---|
| ☐ Loud snoring | ☐ Light snoring | ☐ Pauses in breathing |
| ☐ Grinding teeth | ☐ Twitching of legs or feet during sleep | ☐ Sleep-talking |
| ☐ Sleepwalking | ☐ Head rocking or banging | ☐ Bedwetting |
| ☐ Sitting up in bed but not awake | ☐ Kicking legs during sleep | ☐ Biting tongue |
| ☐ Getting out of bed but not awake | ☐ Becoming very rigid and/or shaking | ☐ Other |

How long have you been aware of the sleep behavior(s) _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

Name of person completing this form: _____

Relationship to patient: _____

# Driving While Drowsy

Excessive Daytime Sleepiness (EDS) can be caused by many different sleep problems and can result in seriously impaired performance and quality of life. We feel obligated to inform you about EDS because of its potential for increased risk of motor vehicle accidents and injuries due to driving while drowsy.

People with EDS often drive drowsy and are twice as likely to be in a car accident when compared with the general population. The car crash is also likely to be more serious, and the rate of personal injury and death due to car crashes amongst people with EDS is three to five times greater than that of the general population. Drowsiness and driving is a dangerous combination. It can be as dangerous as driving drunk. Like alcohol, drowsiness slows reaction time, decreases awareness and impairs judgment.

Only sleep can truly overcome drowsiness. Caffeine may make you feel more alert, but the results are temporary. Turning up the radio, rolling down the windows, getting out of the car and walking, or slapping yourself are not effective means of waking up. The only true remedy for drowsiness is sleep.

If you find yourself becoming drowsy while driving then you should pull over immediately. Options for getting home safely include taking a nap on the side of the road until you are rested enough to drive, calling a friend or family member to come pick you up, or taking a cab or public transportation home. Drowsy driving accidents most often occur when a driver is alone in the vehicle, so carpooling provides someone who can alert the driver of danger and take over behind the wheel if necessary.

The only safe driver is an alert one. Under no circumstances should you drive while drowsy. By using the **Acknowledge — Submit** button below, you acknowledge that you have been informed of the consequences of driving a motor vehicle while drowsy.

**RESET FORM** **PRINT FORM**

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