SMAM
sleep medicine associates of maryland

This questionnaire will provide information about your sleep problem to our Sleep Specialist for a better understanding of your complaint. Please answer each question as completely as possible and circle questions that you would like to discuss in further detail with the physician.

Patient Name: _____ Age: _____ Gender: ☐ Male ☐ Female

SS#: _____ Date of Birth: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Shirt Collar Size: _____

Home Phone: _____ Work Phone: _____

Referring Physician: _____

Please give a brief description of the symptoms that are concerning for a sleep disorder (poor sleep quality, sleepiness, etc.)

_____

_____

_____

_____

_____

How long have these symptoms been a problem?

A. SLEEP HISTORY (may elaborate in space provided at the end of this section)

1. What time do you go to bed on weekdays? _____ AM/PM On weekends? _____ AM/PM
2. What time do you wake up on weekdays? _____ AM/PM On weekends? _____ AM/PM
3. When you go to bed, how long does it usually take to fall asleep? _____ Minutes
4. When awakenings occur, are they associated with:

☐ the need to urinate ☐ snoring

☐ pain ☐ difficulty reinitiating sleep

☐ gasping or choking

5. Upon your final awakening, do you experience:

☐ feeling of refreshment ☐ headache

☐ sleepiness / fatigue ☐ mouth or throat dryness or irritation

6. On the average, how long are you awake in the morning before you actually get out of bed? ___ Mins.

SLEEP HISTORY (cont'd)

7. Do you take naps during the day? ☐ Yes ☐ No

   If yes, what time? _____ For how long? _____ Minutes

8. Does your bed partner describe:

   ☐ Snoring ☐ Limb jerking

   ☐ Pauses in breathing pattern (apneas) ☐ "Restlessness" with tossing and turning

9. Do you feel that you suffer from insomnia? ☐ Yes ☐ No

   (If yes, please describe below)

10. What position do you usually sleep in?

    ☐ On Side ☐ On stomach

    ☐ On back ☐ Combination of all three

11. Have you ever had a previous sleep study? ☐ Yes ☐ No

    If so, when? _____ Where? _____

12. Have you ever used nasal CPAP therapy? ☐ Yes ☐ No

    Duration of treatment? _____ Pressure setting: _____

Have you ever used nocturnal oxygen therapy? ☐ Yes ☐ No

Additional Information:

_____

_____

_____

B. SLEEPINESS

1. Do you wake feeling tired or wanting more sleep regardless of how much sleep you get?

☐ Yes ☐No ☐ Sometimes

2. Do you struggle to stay awake during the day? ☐ Yes ☐ No ☐ Sometimes
3. Have you ever dozed off while driving? ☐ Yes ☐ No
4. Do you fall asleep easily in social situations or meetings? ☐ Yes ☐ No ☐ Sometimes
5. Do you have feelings of depression throughout the day? ☐ Yes ☐ No ☐ Sometimes
6. Do you have difficulty concentrating during the day? ☐ Yes ☐ No ☐ Sometimes
7. Do you believe you have had a change in personality or increased irritability over the past year?

☐ Yes ☐ No ☐ Sometimes

8. Do you believe your “efficiency” performing at work or other tasks is affected by your sleepiness?

☐ Yes ☐ No ☐ Sometimes

9. Do you feel a lack of energy or fatigue throughout the day? ☐ Yes ☐ No ☐ Sometimes

SLEEPINESS (Cont'd)

10. Have you had:

    Loss of sexual interest/libido? ☐ Yes ☐ No ☐ Sometimes

    Erectile dysfunction? ☐ Yes ☐ No ☐ Sometimes

Additional Information:

_____

_____

_____

C. SLEEP QUALITY

1. Do you experience dreams? ☐ Yes ☐ No ☐ Sometimes ☐ Infrequently
2. Do you experience night mares? ☐Yes ☐ No ☐ Sometimes ☐ Infrequently
3. Do your legs or arms bother you when resting or falling asleep or feel "restless" during the day?

   ☐Yes ☐ No ☐ Sometimes
4. Do you grind your teeth during sleep? ☐Yes ☐ No ☐ Sometimes
5. Do you have any unusual sleep behavior (sleep walking, sleep talking)?

   ☐Yes ☐ No
6. Have you ever awoken from sleep with a feeling of muscular paralysis?

   ☐Yes ☐ No
7. Have your dreams ever been so vivid that there was doubt upon awakening whether this was a dream or reality (even hours after awakening)? ☐Yes ☐ No
8. Have you ever developed muscular paralysis during wakefulness (particularly with periods of laughter or excitement)? ☐Yes ☐ No

D. MEDICAL HISTORY (please describe positive answers in space provided at the end of section)

1. Do you have a history of any of the following (please circle):
   a. High blood pressure
   b. Cardiac problems or chest pain
   c. Stroke
   d. Shortness of breath or lung disease
   e. Diabetes
   f. Arthritis or fibromyalgia
   g. Kidney problems
   h. Nasal or sinus problems
   i. Depression or any previous history of requiring care of psychiatrist
   j. Seizures
   k. Head injury

MEDICAL HISTORY (Cont'd)

2. Please list major medical problems not listed above for which you hare followed by a physician or are receiving treatment.

3. Please list any operations you have had including any related to your nose or throat (including tonsillectomy)

4. Please list any medication you take on a regular basis (including sleep aids/stimulants).

Name	Dose	Reason for Taking

5. Please list any allergies and the medication you take on a regular basis for your allergies.

Name	Dose	Reason for Taking

6. Please list any family medical history to any sleep disorders such as snoring, sleep apnea, and narcolepsy.

7. Please list any other significant medical history (cardiovascular, stroke, etc.)

7. a. What is your occupation? _____

b. What hours do you work? _____

Additional Information:

E. HABITS AFFECTING SLEEP (please further describe below if needed)

1. On the average, how many caffeinated beverages do you consume per week? _____
2. Do you use any over the counter caffeine products to maintain wakefulness? ☐ Yes ☐ No
3. Do you exercise regularly? ☐ Yes ☐ No
4. Do you take any hypnotic medications to help initiate sleep? ☐ Yes ☐ No
5. Do you have a history of tobacco use? ☐ Yes ☐ No

If yes, how many cigarettes do you smoke per day? _____

How long have you been smoking? _____

6. Do you currently smoke? ☐ Yes ☐ No
7. On the average, how many alcoholic beverages do you consume per week? _____
8. Have you had any recent change in body weight? ☐ Yes ☐ No

Gained _____ Lbs. Lost _____ Lbs. Over what period of time? _____

9. Have you ever worked shift work? ☐ Yes ☐ No
10. Are there any distractions in your sleep environment (awakening children, nose, phone calls, etc.)? ☐ Yes ☐ No

Additional Information: _____

_____

_____

F. SYSTEM REVIEW (Please circle if you experience any of the following):

1. Chest Pain
2. Dizziness
3. Palpitations
4. Blackout spells
5. Headaches
6. Visual changes
9. Shortness of breath/wheezing
10. Cough
11. Heartburn or reflux
12. Nasal congestion
13. Trouble swallowing
14. Joint or muscle pain

7. Urinary problems
8. Constipation/diarrhea
15. Leg or ankle swelling
16. Calf pain with walking

EPWORTH SLEEPINESS SCALE (ESS)

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* of each situation.

0 = have never done

1 = slight chance of dozing

2 – moderate chance of dozing

3 = high chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down 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	_____

H. SMAM SLEEP APNEA RISK

1. Do you have a history or snoring?
   ( ) No – 0 ( ) Mild/Infrequent = 0 ( ) Moderate/Inconsistent =2 ( ) Sever/Consistent = 8

2. Have you ever been told that you have "pauses" in breathing during sleep?
   ( ) No=0 ( ) Yes/Infrequent=2 ( ) Inconsistent, but most nights =8 ( ) Severely so = 10

3. Are you overweight?
   ( ) No = 0 ( ) <20 lbs= 2 ( ) Between 20 – 50 lbs =3 ( ) >50 lbs =8

4. Evaluate your sleepiness from the ESS Score above.
   ( ) ≤8=0 ( ) 9-13=1 ( ) 14-18=6 ( ) ≥ 19=8

5. Does your medical history include:
   ( ) High blood pressure = 6
   ( ) Heart Disease = 1
   ( ) >3 awakenings/sleep period = 4
   ( ) Depression = 1
   ( ) Stroke = 1
   ( ) Morning Headaches = 1
   ( ) Excessive Fatigue = 1
   ( ) Diabetes, even borderline = 1

Total Score (Add each response above) _____