West Coast Pulmonary Critical Care Physicians, Inc.

Sunset Sleep Disorder Center of Oxnard

Name_____

Date_____

SLEEP QUESTIONNAIRE

My main sleep complaint is:

- ☐ trouble sleeping at night
- ☐ being sleepy all day
- ☐ unwanted behaviors during sleep, explain _____
  _____
- ☐ other, explain _____

USUAL SLEEP HABITS

Bedtime _____ am☐ pm☐

Wake time _____ am☐ pm☐

Number of awakenings_____

Naps per week _____

Duration of sleep problem _____

DIRECTIONS: Check any statement which currently applies to you

- ☐ unrefreshing naps
- ☐ restless sleeper
- ☐ stop breathing during sleep
- ☐ awaken with headaches
- ☐ have high blood pressure
- ☐ cough up sputum or mucus at night
- ☐ falling asleep at inappropriate times
- ☐ refreshing naps
- ☐ vivid dreams
- ☐ paralysis or inability to move on awakening
- ☐ eat excessive amounts of sweets or chocolates
- ☐ driven miles past destination with little awareness
- ☐ legs jerk during sleep
- ☐ experience inability to keep legs still
- ☐ trouble falling asleep
- ☐ awaken long before it is necessary
- ☐ sleep better in unfamiliar setting
- ☐ light sleeper
- ☐ function best in the evening
- ☐ jaws ache in morning
- ☐ bedwetting in adulthood
- ☐ sudden awakening with intense anxiety or dread
- ☐ late sleeper
- ☐ bitter or sour mouth taste in morning
- ☐ hiatal hernia
- ☐ awaken with blood on the pillow
- ☐ awaken with heartburn
- ☐ very loud snorer
- ☐ awaken with choking sensation
- ☐ sweat a lot during sleep
- ☐ difficulty waking in the morning
- ☐ have gained more than 10lbs. in the last year
- ☐ unable to sleep in a flat position
- ☐ driving accidents or near-accidents due to sleepiness
- ☐ dream a lot
- ☐ dreams or hallucinations while awake
- ☐ sudden sensation of weakness in knees or legs
- ☐ was a hyperactive child or teenager
- ☐ kicking or twitching during sleep
- ☐ experience restlessness, tingling or crawling in legs
- ☐ sleep with ear plugs or eye shades
- ☐ trouble returning to sleep
- ☐ don't feel tired at bedtime
- ☐ use sleeping pills
- ☐ bed partner disturbs sleep
- ☐ grind teeth in sleep
- ☐ sleep walking as adult
- ☐ banging, twisting or shaking head during sleep
- ☐ shift-worker or night work
- ☐ heart pain during the night
- ☐ nocturnal seizures
- ☐ awaken with back pain
- ☐ bitten tongue during sleep

MEN

- ☐ awaken with painful penile erections
- ☐ have problems obtaining or maintaining erections

WOMEN

- ☐ sleep problem varies with menstrual cycle
- ☐ sleep problem started or got worse at menopause
- ☐ currently taking birth control pills

FAMILY HISTORY

- ☐ a relative died of "crib death"
- ☐ other family members snore loudly
- ☐ other family members have sudden attacks of muscle weakness
- ☐ other family members fall asleep during the day
- ☐ other family members have the same sleep problem I do

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Glen Abergel, M.D.
Raj Bhatia, M.D.
Ravi Bajwa, M.D.

Name_____

Date Started_____

SLEEPINESS SCALE

DIRECTIONS: Rate the degree of your sleepiness during the day by choosing the statement below that BEST describes your feeling at the time. Write the number of that statement in the appropriate box. Make this rating shortly after you awaken in the morning and every hour during the day.

1. Alert, wide awake, feeling vital, peak alertness.
2. Awake, able to concentrate but not quite at peak.
3 Awake but not fully attentive, responsive but let down.
4. A little foggy, a little sleepy, losing interest, but still able to function.
5. Foggy, prefer to be lying down, slowed down.
6. Very sleepy, woozy, fighting sleep, almost in reverie.
7. Asleep.

	AM						Noon												PM
	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Monday																			
Tuesday																			
Wednesday																			
Thursday																			
Friday																			
Saturday																			
Sunday																			

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SPOUSE OR ROOMMATE QUESTIONNAIRE

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

____ loud snoring
____ light snoring
____ twitching of legs or feet during sleep
____ pause in breathing
____ grinding teeth
____ sleep-talking
____ sleep-walking
____ bed-wetting
____ sitting up in bed but not awake
____ head rocking or banging
____ kicking with legs during sleep
____ getting out of bed but not awake
____ biting tongue
____ becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?_____
_____

Describe the sleep 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. _____

_____

_____

_____

_____

_____

_____

If you have heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”? _____

_____

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DAILY SLEEP LOG

NAME _____

To help us understand your sleep problem, we need a record of the times when you sleep, nap and wake-up during sleep. In addition, we need to know the times when you drink coffee, tea and alcoholic beverages. If medication is taken, record the time the medication is taken. It is important that you keep this record for 10 days. You should give your best guess of the time needed to fall asleep. If you can't recall exactly the time of some events, give your best guess. Each column begins a new day; the first column is an example for you to study.

"A" indicates AM (morning); "P" indicates PM (afternoon or evening).

DAY OF WEEK	EXAMPLE	1	2	3	4	5	6	7	8	9	10
Naps, time begun and how long	4:00 P 1 hr.										
Coffee and tea, number of cups and time drank	7:00 A-1										
Alcoholic drinks, number and time drank	8:00 P-1 9:00 P1 10:00 P-1										
Medications taken, time and amount	Dalmane 30 mg. 10:30 P										
Time went to bed	11:00 P										
Estimated time to fall asleep	45 min.										
Time of awakenings during sleep and length of time awake	3:00 A 1hr 4:30 A 20 min.										
Time of final awaking in the morning	5:30 A										