PULMONICS PLUS PLLC
SLEEP QUESTIONNAIRE

Patient Name_____ **DOB:** _____ **Family Physician:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____@_____

1. What is your main sleep complaint:
   - ❑Snoring
   - ❑ Can't fall asleep
   - ❑Stop breathing in my sleep
   - ❑ Talk or walk in my sleep
   - ❑ Sleepy during the day
   - ❑Other: _____
2. What is your bedtime? _____ What time do you normally awaken? _____ # of naps during the day: _____
   Weekend sleep time _____ Wake time on weekends _____ Do you shift work? _____
3. How long does it take to fall asleep? _____ Do you feel refreshed upon awakening? _____
4. On average how often do you awaken during the night? _____ Why? _____
5. Please list how many caffeinated drinks (including sodas) you take in a day: _____
6. How many cigarettes do you smoke? _____ Alcohol beverages? _____
7. Have you been diagnosed with sleep apnea before? _____ Where & when _____
   If yes, what was your CPAP pressure _____
8. Have you ever dozed off while driving _____

1= N/A (do not know) 2 = Never 3 = 1-2 times weekly 4= 3-4 times weekly 5 = 5-7 times weekly

1. Do you snore in your sleep? 1 2 3 4 5
2. Do you snort in your sleep? 1 2 3 4 5
3. Do you gasp, choke and / or stop breathing in your sleep? 1 2 3 4 5

Please answer the following questions using this scale (consult bed partner if needed):

0= No or Never **1**= Rarely **2**= Sometimes **3**= Often **4**= Frequently **5**= Always

(please circle one)

Sleep Apnea:

0	1	2	3	4	5	I have been told that I **snore**.
0	1	2	3	4	5	I have been told that I **stop breathing** while asleep.
0	1	2	3	4	5	I awaken with a **dry mouth** in the morning.
0	1	2	3	4	5	I awaken with **headaches**.
0	1	2	3	4	5	I awaken during the night **choking or gasping** for air.
0	1	2	3	4	5	I feel **sleepy** during the day.
0	1	2	3	4	5	I have problems with my work because of **fatigue**.
0	1	2	3	4	5	I have to take naps during the day.
0	1	2	3	4	5	After naps in the day I **am fresh** or **not fresh**(circle relevant only)

Others:

0	1	2	3	4	5	I **sleep talk**, **sleep walk**, **grind teeth**(circle relevant only)
0	1	2	3	4	5	I have been told I'm a **restless sleeper**.
0	1	2	3	4	5	I excessively **perspire** at night.
0	1	2	3	4	5	I awaken during the night with **heartburn**.

0	1	2	3	4	5	I have asthma/COPD/wheezing attacks during the night.

Insomnia:

0	1	2	3	4	5	I have trouble **going** (or starting) to sleep at night.
0	1	2	3	4	5	I have trouble **staying or maintaining** sleep at night.
0	1	2	3	4	5	I awaken with feeling of **anxiety or fear**.
0	1	2	3	4	5	I **awaken in the morning**, long before I want to.
0	1	2	3	4	5	I cannot fall asleep because of pain.

Restless leg syndrome or Nocturnal Myoclonus:

0	1	2	3	4	5	I have **aching or crawling sensations** in my legs.
0	1	2	3	4	5	I **stretch** my legs to relieve the aching/crawling sensations.
0	1	2	3	4	5	Symptoms worsen **during** the evening/night as compared to the day
0	1	2	3	4	5	I have been told I kick during the night.
0	1	2	3	4	5	I have **muscle tension** in my legs even when I'm relaxed.
0	1	2	3	4	5	I experience **leg pain** during the night.
0	1	2	3	4	5	I have been told parts of my body "**jerk**".

Sleep Behavior:

0	1	2	3	4	5	I have been told that I "**act out my dreams**".
0	1	2	3	4	5	I have fallen asleep while **laughing** or **crying**.
0	1	2	3	4	5	When I **get angry** or **laugh** I feel like I am going limp or pass out
0	1	2	3	4	5	Sometimes I feel that I **cannot wake up** or **move from sleep**.
0	1	2	3	4	5	I have now, or in the past, had **seizures** in my sleep.
0	1	2	3	4	5	I have noticed **tongue bite** or **urination** in my sleep.

Epworth Sleepiness Score (ESS)

Please use the following scale to choose the most appropriate number for each selection:

1= **slight chance** of dozing or sleeping **2**= **moderate chance** of dozing or sleeping **3**=**high chance** of dozing or sleeping

Situation	Chance of dozing or sleeping
Sitting and reading	1 2 3
Watching TV	1 2 3
Sitting inactive in a public place	1 2 3
Lying down in the afternoon	1 2 3
Sitting and talking to someone	1 2 3
Sitting quietly after lunch (no alcohol)	1 2 3
Stopping for a few minutes in traffic while driving	1 2 3
As a passenger in a car for an hour without a break	1 2 3

TOTAL _____/24

≥10 qualifies for further evaluation, otherwise insurance may not approve