NEUROLOGICAL ASSOCIATES

Home Sleep Testing Questionnaire

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Study Date: ___/___/___ Marital Status: Married Cohabitate Single Divorced Widow/Widower

Email: _____ Phone: _____ Height: _____ Weight: _____

Neck Size: _____

What is your Chief Complaint/Primary reason for testing:

_____

_____

Do you use Tobacco: Y N (if yes) Type:_____ Years: _____ How Much:_____ Quit Date:_____

Do you drink caffeinated beverages: Y N (if yes) Daily consumption: _____ Weekly:_____

Do you drink alcohol: Y N (if yes) Daily consumption: _____ Weekly: _____

Have you or a blood relative been diagnosed with any of the following:

	Personal		Relative	
• **Insomnia**:	Y	N	Y	N
• **Stroke**:	Y	N	Y	N
• **Hypertension**:	Y	N	Y	N
• **Diabetes**:	Y	N	Y	N
• **Sleep Abnormalities**:	Y	N	Y	N

○

Discribe:_____

• **Neurological Disorder**:	Y	N	Y	N

○

Describe:_____

• **NeuroMuscular Disorder**:	Y	N	Y	N

○

Describe:_____

• **Pulmonary Disorder**:	Y	N	Y	N

○

Describe:_____

• **Cardiology Disorder**:	Y	N	Y	N

○

Describe:_____

• **Allergies**:	Y	N	Y	N

○

Describe:_____

- **Depression**(or any other mental issue): Y N Y N
  - ○

Describe:_____

- **Circadian Rhythm Disorder**: Y N Y N
  - ○

Describe:_____

- **Other**: _____

Have you personally been diagnosed with any of the following:

- **Upper Airway Issue** (such as nasal polyps, deviated septum, vocal cord disease) Y N
  - ○ Describe:

_____

- **Gastric Reflux** Y N
- **Hiatal Hernia** Y N
- **Thyroid Issue** Y N
- **Other:** _____

Do you routinely experience the following:

- **Difficulty breathing through your nose** Y N
- **Difficulties with physical exertion** Y N
- **Unusual shortness of breath or chest discomfort** Y N
- **Persistent or Chronic Cough** Y N
- **Excessive phlegm or sputum** Y N
- **Episodes of wheezing or chest tightness** Y N
- **Persistent swelling of ankles or feet** Y N
- **Chronic Pain** Y N
- **Difficulty swallowing (food/drink)** Y N
- **Heartburn/Indigestion** Y N
- **Memory Problems** Y N
- **Sexual Dysfunction** Y N

How would you rate your overall health? Excellent Good Fair Poor

Please list any major surgeries you have had:

Surgery:	**Date:**
_____	_____
_____	_____
_____	_____

Please list ALL of the medications you currently take (if you require more space please include on back or attach a separate sheet):

Name:	**Dose:**	**Reason:**	**Time Taken:**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list any medications you have stopped taking in the last 30 days:

_____

_____

Sleep Habits and Questions

What time do you usually go to bed:_____ What time do you usually wake up: _____

I usually fall asleep in (blank) minutes/hours: _____ I read or watch TV before I fall asleep Y N

I usually sleep for _____ hours a night. I use Oxygen at night Y N Liter flow_____

I use CPAP/BiLevel therapy at night Y N Pressure _____ Mask/Size _____

Please answer the following questions:

- I have been told I snore Y N
- I have been told I talk/walk/eat/or fight in my sleep Y N
- I have very vivid dreams Y N
- I act out my dreams Y N
- When I am excited/surprised my muscles become weak Y N
- I have vivid nightmares Y N
- I wake up and cannot move (paralyzed) for a few minutes Y N
- I have painful erections in my sleep Y N
- I wake up feeling rested and ready for the day Y N
- I have dreams of choking or wake up gasping during the night Y N
- I often have uncomfortable sensations in my legs as I try to sleep Y N
    - Moving my legs helps to relieve these sensations Y N
- I have been told I kick my legs while I sleep Y N
- I exercise within 2 hours of trying to fall asleep Y N
- I wake up hungry during the night Y N
- I have alternating work schedules (day, swing, graveyard) Y N
- I find it easier to wake up very early (before 6 am) Y N
- I find it easier to stay up very late (after midnight) Y N
- I have been told I move around a lot when I sleep Y N

- I try and have the same bedtime each night Y N
- I understand what good sleep hygiene is Y N
- I frequently experience daytime sleepiness Y N
- I find it necessary to take a nap in order to get through my day Y N
- I worry about falling asleep at inappropriate times (driving,working) Y N
- I find it difficult to initiate sleep once I lie down Y N
- My mind races at night and I cannot sleep Y N
- I have trouble staying asleep once I fall asleep Y N

- I use sleeping pills, sedatives or other substances to help me sleep Y N
- I use caffeine or other stimulants to help me wake up/stay awake Y N
- I wake up with heartburn Y N
- I wake up with headaches Y N
- I wake up sweating Y N
- I find it difficult to concentrate or focus during the day Y N

I typically wake up _____ times during the night, of these _____ are to use the restroom.

EPWORTH SLEEPINESS SCALE (EES)

Instructions: Rate the chance that you would doze off or fall asleep during different routine daytime situations. How likely are you to fall asleep in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

ESS SCALE: 0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	Chance of Dozing (0-3)
Sitting and reading	
Watching Television	
Sitting in a public place (i.e., meetings, theater, etc.)	
As a passenger in a car for an hour or more without a break	
Lying down in the afternoon for a rest	
Sitting and talking to someone	
Sitting quietly after lunch	
In a car, while stopped in traffic	
TOTAL	

Home Sleep Study Journal

Name: _____ Date: _____

Please list/describe any difficulty you experienced with the equipment:_____

_____

_____

_____

_____

Please list/describe any difficulty you experienced with the following portions of the study:

Bedtime (Preparing for bed):_____

_____

_____

_____

Nighttime (While you slept):_____

_____

_____

_____

Morning (Disconnecting): _____

_____

_____

_____

Please list/describe any other information you wish the doctor to know regarding your sleep and this study:

_____

_____

_____

_____

_____

_____

Home Sleep Study Bedtime Questionnaire

(To be filled out at bedtime)

Name: _____ Date: _____ Time: _____

How sleepy do you feel right now? (Place a mark along the line)

Very Sleepy _____Very Alert

Please describe how you feel right now by circling one fo the numbers below on the Stanford Sleepiness Scale.

1. Alert. Wide-Awake. Energetic
2. Functioning at a high level, but not at my peak level. Able to concentrate.
3. Awake, but not fully alert.
4. A little foggy, let down.
5. Foggy. Beginning to lose interest in remaining awake. Slowed down.
6. Cannot stay awake. I'm going to fall asleep soon.
7. Asleep.

The following questions pertain to **yesterday** (last night).

1. Please describe your sleep last night._____
2. What time did you turn off the lights and go to bed? _____
3. How long did it take you to fall asleep? _____
4. How many hours/minutes did you sleep last night?_____
5. What time did you wake up this morning? _____
6. How many times did you wake up during the night?_____

Did you nap or fall asleep today? Y N (if yes please describe for how long and when)_____

_____

Was today a typical day? Y N (if NO please explain why)_____

_____

How well do you expect to sleep tonight? _____

Did you drink any alcohol today? Y N (if yes quantity and times)_____

Did you drink any caffeinated beverage today? Y N (if yes indicate how much and what time the last one was)____

_____

Did you smoke or use tobacco today? Y N (if yes please indicate quantity and time of last _____

_____

Did you take a sleep aid? Y N Medications taken today: _____

_____

Please describe any apprehension, anxiety or concerns you are experiencing right now._____

_____

_____

_____

Home Sleep Study Morning Questionnaire (To be filled out when you awaken)

Name: _____ Date: _____ Time: _____

Please circle the best response to the following questions.

All things considered my sleep last night was:

1. Much better than usual
2. Better than usual
3. Same as usual
4. Worse than usual
5. Much worse than usual

Compared to the way I usually feel when I wake up, I feel:

1. Much more alert and awake than usual
2. More alert and awake than usual
3. The same as usual
4. Less alert and awake than usual
5. Much less alert and awake than usual

How long do you feel it took for you to fall asleep last night?_____

Compared to the usual time it takes for you to fall asleep, this was:

1. Much shorter than usual
2. Shorter than usual
3. About the same as usual
4. Longer than usual
5. Much longer than usual

How many hours/minutes do you feel you slept last night?_____

Compared to the usual time you sleep at home, this was:

1. Much shorter than usual
2. Shorter than usual
3. About the same as usual
4. Longer than usual
5. Much longer than usual

I woke up_____times last night. Of these_____times was to use the restroom.

Compared to the usual number of times I wake up, this was:

1. Many times less than usual
2. Fewer than usual
3. About the same as usual
4. More than usual
5. Many times more than usual

I turned the machine on at:_____ I turned the machine off at: _____

I wore CPAP/PAP during the study: Y N Pressure Settings: _____

I wore Oxygen during the study: Y N Liter Flow: _____