BAPTIST SLEEP DISORDERS CENTER
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SLEEP QUESTIONNAIRE

Name____

Have you had prior sleep testing? Yes _____ No _____

If YES, When and Where was this done? ____

Have you been diagnosed with sleep apnea before? Yes _____ No _____

If YES, Are you on a CPAP machine? Yes _____ No _____

DO YOU SNORE LOUDLY (LOUDER THAN TALKING OR LOUD ENOUGH TO BE HEARD THROUGH CLOSED DOORS)? YES ( ) NO ( )

DO YOU OFTEN FEEL TIRED, FATIGUED, OR SLEEPY DURING THE DAYTIME? YES ( ) NO ( )

HAS ANYONE OBSERVED YOU TO STOP BREATHING DURING YOUR SLEEP? YES ( ) NO ( )

DO YOU HAVE OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE? YES ( ) NO ( )

Practitioner to complete

HEIGHT ________ IN WEIGHT __________ LBS BMI __________ ? > 35

AGE ___________ YRS ? > 50

NECK CIRCUMFERENCE ___________ IN ? M > 17; F > 16

GENDER ? M

BP _____ / _____ SpO2 _____ % STOP-BANG Score __________________

Have you ever been told or are you aware of having in your sleep regularly: ***(Please circle)***

Leg jerks / kicking	Leg Cramps	Acting out Dreams
Sleep Talking	Sleep Walking	Paralysis on Awakening
Muscle Weakness with Anger / Laughter		

SLEEP PATTERN:

How long have you had your sleep problem? ______ weeks / months / years

On average, how long does it take you to fall asleep? ______ minutes

What time do you usually go to bed? __________________________

What time do you usually get up? ______________________________

On the average, how often do you wake up during the night? ______ times / night.

On the average, how long do you actually sleep at night? ______ hours

Do you have morning headaches frequently? Yes _____ No _____

Do you have a dry mouth / throat on awakening? Yes _____ No _____

Do you take naps? Yes _____ No _____ How long? _________ hrs

Have you fallen asleep driving? Yes _____ No _____

MEDICAL HISTORY:

Name of Primary Physician / NP: ____

Do you have a history of: ***(Please circle)***

Hypertension	Thyroid Disease	Kidney / Prostate problems
Heart attack	Diabetes	Indigestion / Reflux
Heart rhythm problems	Sinus congestion	Chronic Pain problems
Stroke	Asthma	Night sweats / Hot flashes
Seizures	COPD	Depression / Anxiety

Have you had any of these surgeries? ***(Please circle)***

Tonsillectomy/adenoidectomy	Nasal / Sinus Surgery	Heart Surgery	Pacemaker
Lung Surgery	Weight Loss Surgery	Hysterectomy	Tracheostomy

Please list names of current medications (or provide a list):

____

____

____

____

____

DRUG ALLERGIES: Yes _____ No _____ If yes, list:

____

FAMILY HISTORY:

Any family members with: ***(Please circle)***

Bad snoring	Sleep apnea	Excessive Sleepiness
Narcolepsy	Insomnia	Restless Legs Syndrome

SOCIAL HISTORY:

Occupation ____

Circle all that apply: Married / Single / Divorced / Widowed

For each of the beverages listed below, write in the average you drink each day:

Coffee _____cups Tea _____cups or glasses Soft drinks ____cans or glasses

Do you smoke cigarettes? Yes _____ No _____ How much? __________________

Do you drink alcohol? Yes _____ No _____ How much? __________________

Do you exercise daily? Yes _____ No _____