HCA MIDWEST HEALTH
OVERLAND PARK REGIONAL MEDICAL CENTER

Sleep Disorders Questionnaire

Name _____

Preferred Contact phone number:_____
Work Home Cell (circle)

Height _____ Weight _____ Weight 5 years ago _____ Neck size _____

Referring Physician _____ Family Physician (PCP) _____

Main complaint: _____

When did this problem begin? _____

		(Circle please)
1.	Do you snore loud enough that it bothers others?	Yes No
2.	Has anyone ever told you that you stop breathing in your sleep?	Yes No
3.	Do you ever awaken feeling short of breath, or feel like you can't breathe?	Yes No
4.	Do you have a history of high blood pressure?	Yes No
5.	After a typical night of sleep do you feel refreshed, rested and restored?	Yes No
6.	Do you have "Restless Legs" in the evening, or when trying to fall asleep?	Yes No
7.	Do you ever have trouble falling asleep?	Yes No
8.	What time do you eat your last meal of the day? _____	
9.	At what time during the evening do you stop drinking liquids? _____	
10.	Do you ever have trouble staying sleep?	Yes No
	a. Is it due to frequent urination?	Yes No
11.	Have you ever felt paralyzed either upon awakening or falling asleep?	Yes No
12.	Have you ever had a car accident due to sleepiness?	Yes No
13.	Do you feel a weakness in your knees, neck, or jaw when really angry, or when you are really laughing hard?	Yes No
14.	Do you have very realistic dreams during naps, unintentional sleep?	Yes No
15.	Do you ever awaken to find that you have been acting out a dream?	Yes No

Overland Park Regional Medical Center * phone 913-541-5800 * fax 913-390-7964

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During the **week** my:
Bedtime is: _____
Wake time is: _____

During the **weekend** my:
Bedtime is: _____
Wake time is: _____

On average, I usually get _____ hours sleep per night during the **week**.
On average it takes me _____ minutes to fall asleep.

On average; I usually get _____ hours of sleep per night during the **weekend**.
On average it takes me _____minutes to fall asleep.

I work rotating shifts or permanent nights or evenings ☐ Yes ☐ No
If yes describe: _____
_____

On average I drink _____ caffeinated beverages per day (i.e., coffee, tea, soda).
On average I drink _____ alcoholic beverages per day. I smoke _____ cigarettes per day.

I exercise: ☐ NEVER ☐ RARELY ☐ SOMETIME ☐ FREQUENTLY
(Circle) ☐ Morning ☐ Afternoon ☐ Evening

My current medications are:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please circle the correct answer to the following questions:
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times.
Use the following scale to choose the most appropriate number for the situation.

SITUATION	**CHANCE OF DOSING**			
	Never	Slight	Moderate	High
Sitting and reading	0 ☐	1 ☐	2 ☐	3 ☐
Watching T.V.	0 ☐	1 ☐	2 ☐	3 ☐
Sitting, inactive in a public place (e.g., a theater or meeting)	0 ☐	1 ☐	2 ☐	3 ☐

As a passenger in a car for an hour without a break	0☐	1☐	2☐	3☐
Lying down in the afternoon when circumstances permit	0☐	1☐	2☐	3☐
Sitting and talking to someone	0☐	1☐	2☐	3☐
Sitting quietly after lunch without alcohol	0☐	1☐	2☐	3☐
In a car, while stopped for a few minutes in traffic	0☐	1☐	2☐	3☐

Past Sleep Study and Treatment

_____ I have had a previous sleep disorder evaluation
_____ I have had a previous over night sleep studies
_____ I have had a daytime nap studies
_____ I have been prescribed a CPAP or BIPAP machine for home use
_____ I have had surgical treatment for a sleep disorder
_____ I have previously been prescribed medication for a sleep disorder
Medications: _____

Past Medical History

_____Hypertension (high blood pressure)
_____Heart Disease
_____Diabetes
_____Stomach or colon problems
_____Lung problems/COPD/Asthma
_____Reflux
_____Fibromyalgia/Chronic Fatigue Syndrome
_____Stroke
_____TIA “Light Stroke”
_____Blackouts
_____Seizures
_____Back or joint problems (arthritis)
_____Cancer
_____Thyroid problems
_____Hepatitis (jaundice)
_____Hearing impairment
_____Depression, severe anxiety, panic attacks
_____Alcoholism
_____Chemical dependency or abuse
_____Other:

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List other past medical problems/surgeries and dates:

_____ _____

_____ _____

_____ _____