Date:____________________

Mercy Neurodiagnostic Sleep Center
500 East Market Street
Iowa City, Iowa 52245
(319)339-3625

Patient Sleep Questionnaire

Please complete and bring to your sleep study appointment

Name: ____
(First) (Middle) (Last)

Address: ____
(Street) (City/State) (Zip Code)

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ______________ Height: __________ Weight: ______________

Referring Physician: ____________________

Medication(s): ____

____

____

____

The purpose of the questionnaire is to get a total picture of your background and the nature of your present concerns. Please complete these questions as thoroughly as you can.
This information will be held in the strictest of confidence.

1 Describe your main concerns, including when and how they began and what treatment if any you have received in the past.

2 How long has this problem bothered you?

◯ Longer than 2 yrs. ◯ 1 to 2 yrs. ◯ Several months ◯ Last month

3 On the scale below please estimate the severity of your problem(s):

◯ Upsetting ◯ Severe ◯ Very Severe ◯ Extremely severe ◯ Incapacitating

4 Do any family members have sleep problems? (Please Explain)

Date:____________________

5 On an average, how many hours of sleep do you usually get per night? ____________________

6 Is your sleep often disturbed by: ◯ Heat ◯ Cold ◯ Light ◯ Noise

◯ Other ____________________

7 Do you feel refreshed after sleeping all night? ◯ Yes ◯ No

8 Do you work a split shift or rotating shift? ◯ Yes ◯ No

If yes, explain: ____________________

9 What is your preferred sleeping position? ◯ Back ◯ Side ◯ Stomach

10 On an average, how long does it take you to fall asleep at night? ____________________

11 On an average, How often do you wake during the night? ____________________

12 During the night, do you sleep better in a bed or a chair? ◯ Bed ◯ Chair

13 On average, what amount of these beverages do you drink each day?

Regular Coffee __________ Decaf Coffee __________ Tea __________

Caffeinated Cola __________ Energy Drinks __________ Other Caffeine: __________

Wine __________ Hard Liquor __________ Beer __________ Mixed __________

14 Do you smoke? ◯ Yes ◯ No

If yes: How much? ____________________ How often? ____________________

15 Rate how often you:

	Never	Rarely	Sometimes	Frequently	Sometimes
Snore	______	______	______	______	______
Wake Short of breath	______	______	______	______	______
Wake gasping for breath	______	______	______	______	______
Sweat excessively at night	______	______	______	______	______
Experience loss of muscle tone or weakness when emotional	______	______	______	______	______
Have trouble at school or work due to sleepiness	______	______	______	______	______
Feel unable to move when waking up or falling asleep	______	______	______	______	______
Feel afraid to fall asleep	______	______	______	______	______
I have nightmares	______	______	______	______	______

Date:____________________

	Never	Rarely	Sometimes	Frequently	Sometimes
Remember your dreams	______	______	______	______	______
Notice that parts of your body jerk when resting	______	______	______	______	______
I kick during the night	______	______	______	______	______
Experience crawling or aching sensation in my legs at night	______	______	______	______	______
I fall asleep watching TV	______	______	______	______	______
I fall asleep reading	______	______	______	______	______
I get very sleepy while driving	______	______	______	______	______
I fall asleep at public gatherings	______	______	______	______	______
I wake with morning headaches	______	______	______	______	______
I'm bothered by long periods of wakefulness during the night	______	______	______	______	______
I wake earlier than I would like & have difficulty regaining sleep	______	______	______	______	______
I feel tired during the day	______	______	______	______	______

16 Please answer yes or no to the following questions:

- Have stopped driving because of excessive sleepiness? ◯ Yes ◯ No
- Do you feel refreshed after a short nap (10-15min)? ◯ Yes ◯ No
- Do other people say you snore loudly? ◯ Yes ◯ No
- Do you have trouble getting to sleep at night? ◯ Yes ◯ No
- Are you bothered by frequent awakening during the night? ◯ Yes ◯ No
- Have you ever had vivid dreams shortly after falling asleep? ◯ Yes ◯ No
- Do you routinely nap? ◯ Yes ◯ No

17 Do you drink alcohol at bed time? ◯ Yes ◯ No If yes, how much? ____________

18 are your sleeping habits on the weekend different form the rest of the week? ____________

____

____

19 Have you had any of the following surgeries? ◯ Tonsils ◯ Adenoids ◯ Nasal Septum

20 Have you had a previous sleep study? ◯ Yes ◯ No

If yes, Where? ____________ How Long ago? ____________

Results? ____________

Date:____________________

Please check all that apply:

___ Heart disease	___ High Blood Pressure	___ Low Blood Pressure	___ Heart Attack
___ Atrial Fib	___ COPD	___ CHF	___ Diabetes
___ Headaches	___ Blackouts	___ Fainting	___ Dizziness
___ Ringing in ears	___ Ulcers	___ Seizures	___ Hemophilia
___ Hernia	___ Prostate problems	___ Mental Illness	___ Back problems
___ Gout	___ Asthma	___ Allergies	___ Bronchitis
___ Kidney troubles	___ Bladder trouble	___ Fibromyalgia	___ TIA/Stroke
___ Pneumonia	___ Memory problems	___ Heartburn	___ Impotence
___ Depression	___ Arthritis	___ Muscle Cramps	___ Tuberculosis
___ Diabetes	___ Reflux/GERD	___ Cancer	___ Thyroid problems

Epworth Sleepiness Scale:

Use the following scale to choose the most appropriate answer for each of the following:

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in public place (Theatre, meeting, etc.)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon if able	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3
Sitting and talking to someone	0	1	2	3

Total ____________