Pomona Valley Adult and Children Sleep Disorders Center

Sleep Questionnaire

All Patients

1. What is the Main Reason for this visit? ____
2. How long have you had this problem and what have you done for it so far?
   ____
   ____
3. Occupation ________________Work Times: __________to _________________________
4. For Women: Are you Pregnant? □ **Yes No** □ **If yes, how many weeks are __________**
5. Use of oxygen □ None □ Day □ Night □ Day and Night Oxygen Rate [ ] L/Min
6. Chronic opiate/pain medication use **Yes** □ **No** □

Sleep Habits

7. Number of sleep hours per 24 hour period ____________
8. Number of naps per week ____________
9. Number of awakening during the night ____________
10. List sleeping pills used in the past 3 months: ______________________________________

	Yes	No
Shift work or work at night		
Irregular sleep times		
Naps are refreshing		
Frequently use sleeping pills (including OTC)		
Use of alcohol to sleep		
Drink caffeinated beverages 6 hrs to bed		
Eat Chocolate 6 hrs prior to bedtime		
Watch TV or computer 2 hrs prior to bedtime		
Exercise more than 2 hrs prior to bed		

POMONA VALLEY HOSPITAL

Pomona Valley Adult and Children Sleep Disorders Center

Sleep Time/Awake Time

Typical bedtime _______ Typical awake time__________

Average hours of sleep per day _________ Number of times getting up to urinate _________

Sleep Time:

	Yes	No
Difficulty falling asleep		
Difficulty staying asleep		
Frequent snoring/bed partner states snoring		
Difficulty breathing during sleep		
Wakes due to gasping/snorting		
Sleep with head elevated or in recliner		
Vivid dreams/frequent nightmares when falling asleep awakening		
Difficulty waking up		
Non-restorative sleep/not feeling rested in morning		
Sleepwalking/complex behavior during sleep		
Frequent leg movements during sleep		
Grind teeth during sleep		
Frequent nightmares		

Awake Time:

	Yes	No
Daytime fatigue		
Memory is worse than usual		
Job difficulties because of sleepiness		
Difficulty concentrating because of drowsiness		
Difficulty staying awake when working		
Difficulty staying awake when driving		
Auto driving close calls from sleepiness		
Auto driving accidents from sleepiness		
At risk occupation (truck driver/bus driver)		
Feel need to nap during the day		
Have stress or anxiousness at bedtime		
Frequent morning headaches		
Muscle weakness when excited		
Sleep paralysis (can't move when awakening)		
Aches, cramps or uncomfortable legs before sleep		

Associate Conditions

Check all that apply.

- ☐ Allergies
- ☐ Allergic Sinusitis
- ☐ Arrythmias (heart irregularities)
- ☐ Asthma
- ☐ Barrett's Syndrome
- ☐ Bipolar disorder
- ☐ Bronchitis
- ☐ Bruxism
- ☐ Chronic fatigue syndrome
- ☐ Chronic sinus problems
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Deviated septum or nasal polyps
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Emphysema
- ☐ Enuresis
- ☐ Fibromyalgia, arthritis, rheumatism
- ☐ Grave's Disease
- ☐ Heart attack
- ☐ Heart disease (angina, palpitations)
- ☐ Hiatal hernia/GERD
- ☐ History of head injury/trauma
- ☐ Hypertension
- ☐ Hypothyroidism (low thyroid)
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Nasal polyps
- ☐ Nocturnal cough
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Prader-Willi
- ☐ Restless Leg Syndrome
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Substance abuse
- ☐ TMJ
- ☐ Water retention
- ☐ Other:

Pomona Valley Adult and Children Sleep Disorders Center

Medication	Dose	Times per day

Epworth Sleepiness Scale (ESS)

Please rate the following situations using the key below:

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

1. Sitting and reading _______
2. Watching television: _______
3. Sitting inactive in a public place: _______
4. As a passenger in a car for an hour without a break _______
5. Sitting and talking to someone: _______
6. Sitting quietly after lunch (with no alcohol): _______
7. In a car, when stopped for traffic: _______
8. Lying down to rest in the afternoon: _______

Have you been in a sleep related car accident? Yes ☐ No ☐

POMONA VALLEY HOSPITAL

Pomona Valley Adult and Children Sleep Disorders Center

Tobacco Screening

Smoking tobacco use:

☐Never (less than 100 in lifetime) ☐ 4 or less cigarettes (less than ¼ pack) day in last 30 days.

☐ 5-9 cigarettes (between ¼ to ½ pack) day in the last 30 days

☐ 10 or more cigarettes (1/2 pack or more) day in last 30 days

☐ Cigars or pipes daily within last 30 days

☐ Smoker, current status unknown

☐ Former smoker, quit more than 30 days ago

☐ Refused tobacco status screen

☐ Not obtained due to cognitive impairment

☐ Other:

Ready to quit smoking tobacco: Yes____ No____

Type: ☐ Cigarettes

☐ Cigars

☐ Oral

☐ Pipe

☐ Other:

Smokeless tobacco use:

☐Never

☐ Smokeless tobacco user within last 30 days

☐ Former smokeless tobacco user, quit more than 30 days ago

☐ Refused tobacco status screen

☐ Not obtained due to cognitive impairment

☐ Other:

Exposure to Secondhand Smoke Yes____No_____
Tobacco use per day __________

Number of years__________ Total pack years__________

Started at age: Age ☐ **Year(s)**

Stopped at age: Age ☐ **Year(s)**

Pomona Valley Adult and Children Sleep Disorders Center

Previous treatments:

☐None ☐ counseling ☐Hypnosis ☐Medications

☐Nicotine replacement

☐Other:____

PHQ_2 Depression Screening Questionnaire

In the past 2 weeks, have you experienced?

1. Little Interest or pleasure in Doing things ☐Yes ☐ No
2. Feeling Down, Depressed or Hopeless ☐Yes ☐ No

POMONA VALLEY HOSPITAL

Pomona Valley Adult and Children Sleep Disorders Center

Functional Outcome of Sleep Questionnaire (FOSQ-10)

Subscale Productivity

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?
1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Subscale Vigilance:

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Subscale Social

Q6. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Subscale Activity:

Q7. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Subscale Sexual:

Q 10- Has your sexual desire or intimacy been affected because you are tired or sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No