ANC SLEEP PATIENT QUESTIONNAIRE

Date: _____ Referring provider: _____

Name: _____ DOB: _____

The following table contains symptoms, risk factors, behaviors and other items associated with sleep problems. Check all that apply, even if something occurs only once in a while. If you have a bed-partner or there is someone who has observed your sleep, ask that person to help you complete this form.

SLEEP APNEA

Do you Snore or have been told you Snore?
❑ YES ❑ NO

❑ Heartburn
❑ Gasping/choking
❑ Coughing
❑ pauses in breathing
❑ **Witnessed paused Breathing**
❑ Wakes with headache
❑ Wakes with dry mouth
❑ Mouth breathing
❑ Nasal congestion
❑ Restless sleep
❑ Non-refreshing sleep
❑ Overweight
❑ Recent weight gain
❑ Postmenopausal
❑ High blood pressure
❑ Diabetes
❑ Atrial fibrillation
❑ Coronary artery disease
❑ Age 65 or older
❑ Stroke
❑ Family member with sleep apnea
❑ Previous sleep study
❑ Current CPAP use
❑ Previous CPAP use
❑ Current oral appliance use
❑ Heart attack
❑ Stent placement
❑ Heart pounding

INSOMNIA

❑ **Difficulty falling asleep**
For how long? _____

❑ **Difficulty staying asleep**
For how long? _____

❑ Waking too early
❑ Non-refreshing sleep
❑ Restless sleep
❑ Not getting enough sleep
❑ Irregular sleep schedule
❑ Mind racing
❑ Travel- time zones
❑ Pain or discomfort
❑ Depression
❑ Anxiety
❑ Job stress
❑ Relationship problems
❑ Shift work

DAYTIME PROBLEMS

❑ Feeling Sleepy
❑ Tired no energy
❑ Irritable / moody
❑ Difficulty concentrating
❑ Inattentiveness
❑ Memory problems
❑ Dozing off unintentionally
❑ Napping on purpose
❑ Sleepy while driving
❑ Accident due to sleepiness
❑ Dozing off at work
❑ Dozing off at school
❑ Previous sleep study

PARASOMNIAS

❑ Sleep walking
❑ Sleep talking
❑ Sleep terrors
❑ Sleep eating
❑ Whole body jerks before falling asleep
❑ Body rocking before falling asleep
❑ Vivid dreaming
❑ Acting out dreams
❑ Very restless sleep
❑ Teeth grinding

RESTLESS LEGS

❑ Urge to move legs when trying to sleep
❑ Tingling or crawly feeling in the legs
❑ Urge to move is worse when seated / lying
❑ Moving legs helps relieve discomfort
❑ Symptoms worse in the evening or at bedtime

SLEEP SCHEDULE

Bedtime _____AM/PM

Wake-up_____AM/PM

How long does it usually take you to fall asleep After the light are off? _____min/hrs

On average, how many times do you awaken during the night? _____times

Have you ever had the following kinds of weakness develop suddenly during an emotional situation? For example, when laughing, or if angry or an exciting situation, etc.?

❑ Knees Buckling ❑ Mouth Opening ❑ Head Nodding ❑ Falling Down

EPWORTH SLEEPING SCALE

Do you feel very sleepy or fall asleep during these situations?

It is important that you answer each question as best you can.

0 = would **never** doze 1 = **slight chance** 2 = **moderate chance** 3 = **high chance**

Situation	**Chance of Dozing (0-3)**			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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 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 or at a red light	0	1	2	3
Total Score				**/24**

Occupation: _____ How Long? _____

Date: _____ Patient Signature: _____

(For provider use only)

Related Comorbid Condition

❑ Hypertension
❑ Stroke/TIA
❑ COPD
❑ CHF
❑ PLMD
❑ RBD
❑ Sleep talking
❑ Sleep walking
❑ Bruxism (Grinding Teeth)
❑ Unspecified Insomnia
❑ Diabetes
❑ Neuro Muscular Disorder
❑ Epilepsy/Seizures
❑ Leg jerking
❑ Other_____

Related Examination Findings

B/P Reading: _____ Nk Circumference: _____

Mallampatti: 1 2 3 4 Edema: ❑ Yes ❑ No

Provider Notes: _____

_____

_____

_____

Providers Signature

Advanced Neuroscience Clinic and Sleep Center, P. A.

Insomnia Severity Index

Date: _____ **Referring provider:** _____

Name: _____ **DOB:** _____

For each question, please *CIRCLE* the number that best describes your answer.

Please rate the *CURRENT (i.e. LAST 2 WEEKS) SEVERITY* of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0-7 = No clinically significant insomnia
8-14 = Subthreshold insomnia
15-21 = Clinical insomnia (moderate severity)
22-28 = Clinical insomnia (severe)

Advanced Neuroscience Clinic and Sleep Center

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Date: _____

Name: _____ **DOB:** _____

Height_____Weight _____Age_____Male / Female (please Circle)

STOP		
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 daytime?	Yes	No
Has anyone **OBSERVED** you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **PRESSURE**?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8
Intermediate risk of OSA: Yes 3 - 4
Low risk of OSA: Yes 0 – 2