SLEEP CENTER OF YUMA

ASHVIN SHAH M.D., PCCP, P.C.

2110 W. 24TH STREET
YUMA, AZ. 85364
PHONE: (928) 344-1891
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SLEEP QUESTIONNAIRE

PATIENT NAME:______________________________ D.O.B.______________

BED PREP HABITS

DO YOU PERFORM ANY OF THE FOLLOWING IN BED? READ/WATCH TV/WORRY/WRITE/ARGUE/NONE

1. What is your reason for visiting the Sleep Center today?______________
2. What is your primary sleep complaint?______________
3. Have you ever been diagnosed with ANY type of sleep disorder? YES/NO – if so, how long ago and where was the diagnosis made?______________
4. Have any family members been diagnosed with a sleep disorder? YES/NO – Who?__________
5. Describe the type of work you do:______________
6. Do you have a regular sleep partner? YES/NO
7. Any recent weight gain? YES/NO – If so, how much?______________
8. Have you ever fallen asleep while driving a car? YES/NO
9. Have you ever had hallucinations or exceptionally vivid dreams while falling asleep? YES/NO
10. Have you ever felt sudden muscle weakness when laughing, angry or surprised? YES/NO
11. Have you ever felt paralyzed or unable to move just when falling asleep or waking up? YES/NO
12. Do you snore? OCCASIONALLY/FREQUENTLY/ALWAYS/UNSURE/NEVER
    a. If you snore, rate yourself on a scare from 1 – 10 (10 being the loudest) __________
    b. How would your sleeping partner rate your snoring with the same scare?__________
    c. What position affects your snoring, if any? BACK/RIGHT SIDE/LEFT SIDE/STOMACH
13. Do you wake up with any of the following?
    COUGHING/CHOKING/RAPID HEARTBEAT/HEADACHE/ACID TASTE/DRY MOUTH/SORE THROAT

PROBLEMS DURING SLEEP

1. Do you have problems falling asleep due to any of the following?
   TROUBLE RELAXING/PAIN OR DISCOMFORT/ RACING THOUGHTS
2. Does waking too early and not going back to sleep bother you? YES/NO/SOMETIMES
3. Do you have prolonged periods when you are awake and can't go back to sleep?
   YES/NO/SOMETIMES
4. Do you frequently check the clock when you are unable to sleep? YES/NO/SOMETIMES
5. Has your mood or thought process changed recently? YES/NO/SOMETIMES
6. Within the last year, has depression, anxiety or stress interfered with your sleep?
   YES/NO/SOMETIMES
7. Do you have nightmares? YES/NO/UNSURE
8. Any history of bed wetting? YES/NO/UNSURE
9. Do you sleep walk? YES/NO/UNSURE
10. Do you grind your teeth? YES/NO/UNSURE
11. Do you use a mouth device? YES/NO
12. Are your covers messy in the morning? YES/NO
13. Do you thrash in your sleep? YES/NO/UNSURE
14. Have you ever kicked or hit your partner in your sleep? YES/NO/UNSURE
15. Do you have episodes of flailing your arms/kicking your legs/screaming in your sleep? YES/NO
    If so, do you recall dreaming during the episode? YES/NO Become confused? YES/NO
    Do you remember the episode in the morning? YES/NO
16. Has anyone ever said that you stop breathing in your sleep? YES/NO

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SLEEP TIMES

NORMAL BEDTIME__________ NORMAL WAKE TIME________ BEDTIME ON NON-WORKDAYS________
WAKE TIME ON NON-WORKDAYS____________ HOW MANY HOURS DO YOU NORMALLY SLEEP?________
HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?________ HOW OFTEN DO YOU GET UP AT NIGHT?________
HOW LONG DOES IT TAKE YOU TO GET BACK TO SLEEP?________ WHAT WAKES YOU UP?____________
DO YOU HAVE A HARD TIME GOING BACK TO SLEEP?______ DO YOU HAVE ANY MEMORY PROBLEMS?________
DO YOU NAP? YES/NO – IF SO, ARE YOUR NAPS REFRESHING? YES/NO
ARE YOU SLEEPY DURING THE DAY? YES/NO

SLEEP DISTURBANCES

MY SLEEP IS FREQUENTLY DISTURBED BY THE FOLLOWING *(Circle any that apply):*
CHILDREN/BED PARTNER/PETS/INDIGESTION/PAIN/LEGDISCOMFORT/HEADACHES/NAUSEA/CHOCKING-GASPING FOR AIR/SINUS OR COLD SYMPTOMS/SHORTNESS OF BREATH /ASTHMA/FRIGHTENING DREAMS/NEED TO URINATE/HUNGER/COUGH/THIRST/NOISE/STRESS/NONE

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS IN CONTRAST TO JUST FEELING TIRED?

0 = never 1 = slight chance 2 = moderate chance 3 = high chance

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public space (e.g. theater or meeting)	0	1	2	3
As a passenger in a car for an hour without 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	0	1	2	3

HABITS

Do you smoke? YES/NO – if so, how many per day?______________
Do you drink alcohol? YES/NO/RARELY – if so, how many on work days?______ Weekends?________
Do you drink caffeine? YES/NO – if so, what kind? TEA/SODA/COFFEE/ENERGY DRINKS
How many cups per day?______________

MEDICAL HISTORY

Circle all that apply:
HIGH BLOOD PRESSURE/CLAUSTROPHOBIA/DEPRESSION/DIABETES/HEART DISEASE/ GERD/NASAL OR SINUS PROBLEMS/OTHER THROAT OR NOSE SURGERY/PANIC ATTACKS/SEIZURES/THYROID DISEASE/ LUNG DISEASE/STROKE NONE/OTHER:____________________________

Have you ever had surgery for sleep apnea? YES/NO – If so, when?____________________