Associated Neurological Specialties and Sleep Disorder Center

1180 Seton Parkway, Suite 300 ❖ Kyle, Texas 78640 ❖ p: (512) 551-0846 ❖ f: (512) 828-8785

4407 Bee Caves Road, Bldg. 3, Suite 301 ❖ Austin, Texas 78746 ❖ p: (512) 458-2600 ❖ f: (512) 454-2292

Neeraj Manchanda, MD Rani Das, MD

Sleep Center Questionnaire

Name:_____Sex:_____Age:_____Date:_____

Date of Birth:_____Height:_____Weight:_____Neck Size:_____

Primary Care Physician:_____Referring Physician:_____

Main Sleep Issues/Complaints

____Trouble falling asleep ____Trouble staying asleep

____Snoring ____Excessive drowsiness during the day

Other, please describe_____

For how long?_____

Prior Sleep Disorder Diagnosis or Studies

I have a prior sleep diagnosis of _____

My prior sleep studies (where, when) _____

I am currently prescribed: _____CPAP or ____Bilevel pressure Settings: _____cmH20

I use Oxygen during the:_____day_____night _____both

Yes No I have had surgery for sleep disorder. _____UPPP _____Tonsillectomy____Other

Yes No I use a dental device for my sleep disordered breathing

Sleep Pattern

Typical Bedtime: _____weekday _____weekend

Typical Awakening time: _____weekday _____weekend

How many hours of sleep do you feel you sleep at night?: _____

Typical amount of time it takes to fall asleep (min/hrs): _____

Typical number of awakenings per night: _____

Yes No I awaken early in the morning, still tired

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Insomnia

Yes No I have trouble falling asleep.
Yes No Thoughts start racing through my mind when I'm trying to fall asleep.
Yes No I have trouble remaining asleep.
Yes No I have difficulty returning to sleep if I awaken during the night.

Daytime Sleepiness

Yes No I often feel drowsy during the daytime, more than I expect is normal.
Yes No I take daytime naps. If yes, how many? _____
Yes No I have uncontrollable urges to fall asleep during the daytime.
Yes No I have experienced lapses in time and blackouts.
Yes No I have fallen asleep while driving.
Yes No I don't perform to the best of my abilities in school/work because of sleepiness.

Breathing

Yes No I have been told that I snore loudly.
Yes No I have been told that I stop breathing.
Yes No I have been told that I snore only when sleeping on my back.
Yes No I have been awakened by my own snoring.
Yes No I have awakened at night from choking or gasping for air.
Yes No I have trouble breathing when lying flat on my back.
Yes No I have trouble breathing through my nose.
Yes No I have morning headaches.
Yes No I sweat a great deal at night.

Sleep Environment/Habits

Yes No My typical sleep position(s) are on my back, side, stomach, or head elevated in a chair.
Yes No I sleep alone.
Yes No My bedroom is comfortable.
Yes No I have pets in my bedroom.

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Yes No I watch TV prior to sleeping.
Yes No I read in bed.
Yes No I drink alcohol prior to bedtime.
Yes No I smoke prior to bedtime or I wake up during the night.
Yes No I eat a snack at bedtime.
Yes No I eat if I wake up during the night.

RLS

Yes No I kick or jerk my legs excessively during sleep and bother my bed partner.
Yes No I experience a creeping-crawling sensation in my legs when trying to fall asleep.
Yes No I experience an inability to keep my legs still prior to falling asleep.
Yes No I experience a feeling of restlessness in my legs at night.

Parasomnia

Yes No I act out my dreams while asleep.
Yes No I have frequent nightmares.
Yes No I talk in my sleep.
Yes No I have sleep walked as an adult.

Orexin Related

Yes No I have experienced sudden muscle weakness in response to laughter, anger, or surprise.
Yes No I have experienced an inability to move while falling asleep or waking up.
Yes No I have experienced hallucinations or dreamlike images when falling asleep or waking up.
Yes No I frequently dream during daytime naps.

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Epworth Sleepiness Scale

Use the following to choose the **most appropriate number** for each situation:

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

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

Situation	Chance of Dozing
Sitting & Reading	
Watching TV	
Sitting, inactive in a public place (theater or meeting)	
Passenger in a car for about an hour with no break	
Lying down to rest in afternoon when circumstances permit	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes with traffic	

Miscellaneous (Circadian, GERD, Depression, Enuresis, Bruxism, Pain)

Yes No I frequently travel across two or more time zones.

Yes No I am more alert in the morning than in the evening.

Yes No I am more alert in the evening than in the morning.

Yes No I wake up alert in the morning, earlier than when I actually have to get up.

Yes No I frequently have heartburn or acid reflux at night.

Yes No I feel depressed.

Yes No Chronic pain interferes with my sleep.

Yes No The need to urinate frequently interrupts my sleep.

Yes No I grind my teeth in my sleep

Yes No I have enuresis (bed wetting).

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Habits

Yes No I smoke cigarettes (or other tobacco). If yes, how much and how often? _____

Yes No I drink alcohol. If yes, how much and how often? _____

Yes No I drink caffeinated beverages (e.g. tea, coffee, soda). _____cups/beverages

Social History

Marital Status: Single Married Divorced Widowed Separated

Employment status: Unemployed Disabled Student Retired

Employed Occupation: _____

Yes No I regularly work night shifts.

Yes No I work rotating shifts, including night shift work.

Past Medical History (Check all that apply)

___Hypertension ___Coronary Artery Disease ___Congestive Heart Failure

___Stroke ___Seizures ___COPD/Asthma

___Diabetes ___Cancer ___Thyroid Problems

___Depression or Anxiety ___Alcoholism ___Chemical Dependency

___Sinus Disease ___Nasal Fracture

___Alergic Rhinitis/Nasal Congestion

___Reflux (GERD) Stomach or Colon Problems

___Fibromyalgia Back or Joint Problems (Arthritis)

Other: _____

Females: ___Premenstrual Syndrome ___Menopause

Males: ___Prostate Problems ___Erectile Dysfunction

Prior Surgeries: _____

Weight change during the past year: Gained____lbs Lost____lbs

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