Tranquility Sleep Specialists, PLC

INITIAL SLEEP APNEA QUESTIONNAIRE

Date:______________________________

Name: ____ Gender: ☐ Male ☐ Female

Date of birth:______/______/______ Age:________ Height:_____ft. ______in. Weight:________lbs.

Why are you here? ____

____

____

____

Were you ever diagnosed with a sleep problem in the past? ☐ Yes ☐ No

If yes, who did you see for this, what was the diagnosis, and what treatment was recommended?

____

____

____

Do you feel you need more sleep at night? ☐ Yes ☐ No

How many times do you wake up during the night?_______

Why do you wake up? ____

Do you usually feel unrefreshed after a night of sleep? ☐ Yes ☐ No

Epworth Sleepiness Scale

How likely are you to doze off in the following situations, in contrast to just feeling tired? This refers to a typical day in the last few months. If you have not been in some of these situations recently, try to imagine how likely it would be that you would fall asleep in those situations. 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 a public place (theater, 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 when able	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL: ______________________

Tranquility Sleep Specialists, PLC

The Fatigue Severity Scale

Circle a number from 1 to 7 that indicates the degree of agreement with each statement.
1 indicates strongly disagree and 7 indicates strongly agree.

1. My motivation is lower when I am fatigued	1 2 3 4 5 6 7
2. Exercise brings on my fatigue	1 2 3 4 5 6 7
3. I am easily fatigued	1 2 3 4 5 6 7
4. Fatigue interferes with my physical conditioning	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life	1 2 3 4 5 6 7

TOTAL: ______________________

Do you feel excessively sleepy during the day? ☐ Yes ☐ No
Do you feel fatigued (listless, no energy) during the day? ☐ Yes ☐ No
Do you nap during the day? ☐ Yes ☐ No
If you drive, please complete the following:
Have you ever fallen asleep while driving or while stopped at a light? ☐ Yes ☐ No
Have you ever had an accident or near accident due to falling asleep driving? ☐ Yes ☐ No
Do you use caffeine (beverages or tablets)? ☐ Yes ☐ No
If yes, how many:
________ tabs/day
________ cups coffee/day
________ cups hot tea / day
________ glasses iced tea
________ cans (bottles) soft drink/day
If yes, around what time do you have your last caffeine?
________ [ ] am [ ] pm

Have you recently gained weight? ☐ Yes ☐ No
What position do you prefer to sleep in?
☐ Back ☐ Side ☐ Stomach ☐ Other:______________________________
Do you snore? ☐ Don't know ☐ Yes ☐ No
Has anyone ever said that you stop breathing in your sleep? ☐ Yes ☐ No
Do you wake up snorting, choking, or gasping for air? ☐ Yes ☐ No
Do you wake up with a dry mouth or a sore throat? ☐ Yes ☐ No
Do you breathe through your mouth when you sleep? ☐ Yes ☐ No
Do you wake up in the mornings with a headache? ☐ Yes ☐ No
Do you have problems with concentration or memory? ☐ Yes ☐ No
Do you use (have you used) any of the following when you sleep? ☐ Yes ☐ No
☐ Oxygen ☐ CPAP ☐ BiPAP
☐ Other positive pressure device: ______________________________

Do you wake up with an acidic/sour taste in your mouth at night? ☐ Yes ☐ No
Do you have heartburn at night? ☐ Yes ☐ No

Tranquility Sleep Specialists, PLC

Medical History

Do you have a history of any of the following:

- ☐ Allergies
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Broken nose or facial bone
- ☐ Chronic fatigue syndrome
- ☐ Concussion
- ☐ Coronary artery disease
- ☐ Dental problems
- ☐ Depression
- ☐ Deviated nasal septum
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gastric reflux (heartburn)
- ☐ Heart failure
- ☐ Heart surgery
- ☐ Heart valve disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypo / hyperthyroidism
- ☐ Kidney disease
- ☐ Myocardial infarction
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Sinus problems
- ☐ Stroke
- ☐ Other: ____________________

Surgical History

List all past surgeries and the year performed.

____

____

____

____

____

____

Tranquility Sleep Specialists, PLC

Family History

Do/Did any of your blood relatives have insomnia, daytime sleepiness, narcolepsy, night terrors, restless legs syndrome, sleep apnea, sleep walking, epilepsy? ☐ Yes ☐ No

Other medical conditions in your family:

Condition	Affected relative
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Social History

Current occupation:______________________________

Marital Status:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Single
- ☐ Cohabitating

Habits

Do you or have you ever smoked or chewed tobacco? ☐ Yes ☐ No

If yes, number of packs / day:__________ number of years:__________

If quit, when did you quit?__________

Review of Systems

Please indicate if you have recently had any of the problems listed below:

Respiratory: ☐ shortness of breath at rest ☐ shortness of breath with exertion ☐ chronic cough ☐ coughing up blood ☐ wheezing

Cardiovascular: ☐ chest pain ☐ passing out or feeling like you may ☐ pain in legs with exertion ☐ difficulty breathing when lying down ☐ waking up short of breath ☐ palpitations ☐ ankle swelling

Neurologic: ☐ memory loss ☐ difficulty concentrating ☐ weakness ☐ falls or trouble walking ☐ loss of or abnormal sensations ☐ loss of coordination or balance ☐ abnormal movements ☐ muscle wasting ☐ loss of consciousness ☐ tremor

Psychiatric: ☐ depression ☐ anxiety ☐ stress ☐ thoughts of hurting yourself or someone else

Tranquility Sleep Specialists, PLC

Bed Partner Questionnaire

Name of Patient: ______________________________ Date: ______________

Name of Bed Partner: ______________________________

Check any of the following behaviors you have observed this person doing *while asleep:*

- ☐ light or loud snoring
- ☐ twitching or jerking of arms during sleep
- ☐ getting out of bed but not awake
- ☐ sitting up in bed but not awake
- ☐ becoming very rigid and/or shaking
- ☐ pause in breathing
- ☐ bed wetting
- ☐ awakening with pain
- ☐ twitching or kicking of legs during sleep
- ☐ choking
- ☐ crying out
- ☐ grinding teeth
- ☐ sleep walking
- ☐ tongue biting
- ☐ occasional loud snorts
- ☐ head rocking or banging
- ☐ Other: ______________________________

____

Describe the sleep behavior(s) checked in more detail. Include a description of the activity, time of night, frequency when it occurs, and if it occurs every night:

____

____

____

____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?
☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

____

____

PATIENT MEDICATION LIST

Tranquility Sleep Specialists

Name: ____ Date first filled out: ____________

If this is your first time filling out this form: Please enter your allergies, medical equipment, medications, dosages, and dosing frequency. Please include all vitamins, over the counter medications, and herbs.

If you are filling this out at a return visit: Please put a check in the box under the current date next to each medication you are still taking. If you are taking a new medication, please add it to the list. Please do not mark out medications you are no longer taking.

Medication Allergies: ____

			Date of visit										
Medication/Medical Equipment	Dosage	Frequency											