Sleep Better SOUTH CAROLINA

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SLEEP QUESTIONNAIRE

*Name:_____ Gender: ☐ Male ☐ Female

*Birthdate:_____ Age:_____

Phone:_____ Email:_____

Address:_____City:_____State:_____

*Referring Dr. or Clinic:_____

*Height:_____ *Weight:_____ *BMI:_____ *Neck Size (inches):_____

***These fields are required**

***Instructions**: Check the appropriate box below to rate your **Chance Of Dozing** for each situation.*

Points Each:	***0***	***1***	***2***	***3***
Sitting and reading:	☐ Never	☐ Slight	☐ Moderate	☐ High
Watching TV:	☐ Never	☐ Slight	☐ Moderate	☐ High
Sitting inactive in a public place:	☐ Never	☐ Slight	☐ Moderate	☐ High
Passenger in a car for an hour:	☐ Never	☐ Slight	☐ Moderate	☐ High
Laying down in the afternoon:	☐ Never	☐ Slight	☐ Moderate	☐ High
Sitting and talking to someone:	☐ Never	☐ Slight	☐ Moderate	☐ High
Sitting quietly after lunch:	☐ Never	☐ Slight	☐ Moderate	☐ High
Stopped in a car for a few minutes:	☐ Never	☐ Slight	☐ Moderate	☐ High
TOTAL From Points Each:	☐ +	☐ +	☐ +	☐ = ☐

***Instructions**: Check the appropriate box below for each question.*

Do you snore? ☐ Yes ☐ No ☐ Don't Know

If you snore, your snoring is:

- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Louder than talking- can be heard in adjacent rooms

How often do you snore?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

Has your snoring bothered other people?
☐ Yes ☐ No ☐ Don't Know

Has anyone noticed that you quit breathing in your sleep?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

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***Instructions**: Check the appropriate box below for each question.*

How often do you feel fatigued or tired after you sleep?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

During your waking time, do you feel tired, fatigued or not up to par?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

Do you have high blood pressure?

☐ Yes ☐ No ☐ Don't Know

Have you ever fallen asleep or nodded off during driving a vehicle?

☐ Yes ☐ No

If yes, then how often does this occur?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

Check box for each that applies to you.

Sleep Symptoms

- ☐ Frequent bathroom visits nightly
- ☐ Gasping, choking or snorting during sleep
- ☐ Restless legs
- ☐ Limbs jerking/twitching at night
- ☐ Morning headache
- ☐ Insomnia
- ☐ Restless sleep
- ☐ Memory loss
- ☐ Teeth grinding/clenching
- ☐ Waking up paralyzed
- ☐ Audible or visual hallucinations around sleep
- ☐ Family history of sleep apnea

Previous Sleep Diagnoses & Treatment

- ☐ Overnight Oximetry
- ☐ MediByte or Type 3 Home Sleep Test
- ☐ Sleep Study in a lab
- ☐ CPAP or BiLevel Therapy
- ☐ Dental Splint for snoring or Oral Sleep Apnea (OSA)

Check box for each that applies to you.

Health Issues

- ☐ Heart disease
- ☐ Stroke
- ☐ COPD
- ☐ Other lung disease
- ☐ Gastric acid reflux
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Previous oral/nasal surgery
- ☐ Other(list)_____
- ☐ Oxygen use
- ☐ Pace maker
- ☐ Depression
- ☐ Erectile dysfunction
- ☐ Alcohol consumption (specify below)
  - ☐ Daily
  - ☐ 3-5 times a week
  - ☐ weekends
  - ☐ special occasions

Medications (list below names only, not doses)

By signing, you attest all answers are truthful:

_____ _____

***Signature** **Date**