



SLEEP DIAGNOSTIC CENTER

2522 W. Peterson
Chicago, Illinois 60659

Policy and Procedure: Direct Referral for Sleep Studies

Policy #: OS6.2

Effective Date: 11/17/09

Last Revision Date:

Category: Office and Scheduling Procedures

Approved:

Initial Questionnaire

Patient Name _____ Age _____ Date _____

Height _____ Weight _____

Main Complaint _____

Please select the best answer that represents your normal sleep.

1. Do you feel that you:

• get too little sleep at night?	Yes	No
• get too much sleep at night	Yes	No
• have trouble getting a good night's sleep?	Yes	No
• have trouble getting to sleep at night?	Yes	No
• have trouble staying asleep at night?	Yes	No
• have trouble getting up in the morning?	Yes	No
• have non-refreshing sleep?	Yes	No
• are sleepy during the day?	Yes	No
• are tired (fatigued) during the day?	Yes	No

2. What time do you usually go to bed? _____

3. Does this time vary? _____

4. How long does it usually take you to fall asleep? _____

5. On average, how many hours of sleep do you get each night? _____

6. When trying to fall asleep, how often do you:

	Never	Some	Often
• have thoughts racing through your mind?	___	___	___
• feel sad or depressed?	___	___	___
• have anxiety/worry about things?	___	___	___
• feel muscular tension?	___	___	___
• feel afraid of not being able to sleep?	___	___	___
• feel unable to move?	___	___	___
	Never	Some	Often
• have a creeping, crawling, aching or twitching			



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in your limbs making you feel you have to move them?

- have any kind of pain or discomfort?
- feel afraid of the dark or anything else?
- feel afraid you won't return to sleep?

7. How many times do you usually awaken each night? _____
8. Do you have trouble getting back to sleep? _____
9. On a typical night, what is your longest period of wakefulness? _____
10. How long are you awake all together during the night? _____
11. Do you usually wake up during the first or latter part of the night? _____

- | 12. How often do you: | Never | Some | Often |
|---|--------------------------|--------------------------|--------------------------|
| • sleep with someone else in your bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • sleep with someone else in your room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have restless, disturbed sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • get up at night to attend to your children? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • snore loudly and/or disruptively? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • hold your breath or stop breathing while you sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have nasal congestion during the night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • suddenly awaken gasping for air? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have some other breathing problem at night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • feel your heart pounding during the night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • sweat a lot during the night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • walk in your sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • fall out of bed while asleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • wake up screaming, violent or confused? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have unusual movements while asleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • wet the bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • grind your teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have a night full of intense, vivid dreams? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have nightmares? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • wake up from a dream? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have racing thoughts during your sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • have a recurring dream that disturbs your sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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13. What time do you usually wake up in the morning? _____

14. What time do you usually get out of bed? _____

15. How often do you:	Never	Some	Often
• depend on an alarm clock to wake you up?	___	___	___
• "sleep-in" in the morning (more than one hour past your normal time to get up)?	___	___	___
• have a very hard time waking up?	___	___	___
• feel unable to move when waking up?	___	___	___
• have dream-like images when waking up even when you know that you are not sleeping?	___	___	___
• wake up confused or disoriented?	___	___	___
• wake up with a headache?	___	___	___
• wake up with a dry mouth?	___	___	___

16. Have you ever slept or been overwhelmingly sleepy for several days at a time? Yes No

18. Have you ever been unable to sleep for several days at a time? Yes No

19. Do you feel that your sleep is abnormal? Yes No

20. If you have or have had a sleep or sleepiness problem, was it worse at any time in the past? Yes No

21. Have you ever had any trouble with sleep during your childhood? Yes No

22. _____

	Never	Some	Often
23. How often do you feel extremely alert and energetic during the day?	___	___	___

24. How great a problem do you have with <i>fatigue</i> (tiredness, exhaustion or lethargy) even when you are not sleepy?	___	___	___
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25. How great of a problem do you have with *sleepiness*



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- (sleepy or struggling to stay awake) in the daytime? _____
26. How often do you fall asleep unintentionally? _____
Please give an example: _____
27. How often do you feel sad or depressed? _____
28. How often do you feel muscular tension? _____
29. How often do you feel weakness in you muscles when laughing, being surprised, angry, excited, etc.? _____
30. How great of a problem do/did you have with your education because of sleepiness/fatigue? _____
31. How great of a problem do you have with your performance at work because of sleepiness/fatigue? _____
32. How many times have you ever had accidents at work because of sleepiness/fatigue? _____
33. How many times have you been involved in automobile accidents? _____
35. How many rest (not sleeping) periods do you usually take in a weekday? _____
36. How many times in a usual weekday do you try to take a nap but can't sleep? _____
37. How long is your nap and/or rest periods? _____
38. Do you feel refreshed after your naps? _____ rest periods? _____
39. How long do you feel refreshed after a nap? _____ rest periods? _____
41. How often do you: Never Some Often
- experience vivid dream like images while falling asleep or awakening from a nap even though you know you are still awake? _____



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- have vivid dreams during a nap?
- feel unable to move while falling asleep or waking up?
- discover that you have performed a complex act such as driving a car, and not remembered how you did it?
- find yourself doing things which make no sense (such as writing nonsense or mixing chocolate and gravy)?
- get told that you were acting strangely without your being aware of it at the time?
- have a feeling of "weak knees" when you laugh?
- have episodes of sudden muscular weakness (paralysis or inability to move when laughing, angry, emotional situations)?

42. Do you think you are excessively sleepy during the daytime? Yes No

43. Do you have any problems with:

- nasal congestion, obstruction or discharge? Yes No
- swallowing? Yes No
- a lump of obstruction in your throat? Yes No
- has your voice changed in the last year? Yes No

44. Please check any problems or illnesses you have or have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> headaches | <input type="checkbox"/> black outs |
| <input type="checkbox"/> fainting | <input type="checkbox"/> dizziness | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> hemophilia | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> hernias | <input type="checkbox"/> prostrate trouble | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> back problems | <input type="checkbox"/> gout | <input type="checkbox"/> asthma |
| <input type="checkbox"/> allergies | <input type="checkbox"/> bronchitis | <input type="checkbox"/> kidney trouble |
| <input type="checkbox"/> bladder trouble | <input type="checkbox"/> eye trouble | <input type="checkbox"/> hearing trouble |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> meningitis | <input type="checkbox"/> heartburn/gas |
| <input type="checkbox"/> impotence | <input type="checkbox"/> depression | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> muscle cramps | <input type="checkbox"/> tuberculosis | |

45. Surgeries & Hospitalizations – Please list any hospitalizations and/or surgeries you have had. Include where, what, why and when.

- _____
- _____



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- _____
- _____
- _____

46. Medications – List name/dose of all medication you are taking now or in the last 30 days.

- _____
- _____
- _____
- _____
- _____

47. How much of these fluids do you drink?

	During a 24 hour period	Within 2 hours of bedtime
Coffee	_____ cups	_____ cups
Tea	_____ cups	_____ cups
Cola drinks	_____ cups	_____ cups

48. How many alcoholic drinks do you have during a 24 hour period?

Please list for weekends _____

Please list for weekdays _____

49. How often have you:

	Never	Some	Often
• used alcohol in order to get to sleep?	___	___	___
• had DT's, rumfits, shakes or hallucinations associated with drinking alcohol?	___	___	___
• had detoxification or other treatments for excessive drinking?	___	___	___

50. How much do you typically smoke in a 24 hour period?

- packs of cigarettes _____
- cigars _____
- pipe _____



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53. How often do you use:	Never	Some	Often
• marijuana?	_____	_____	_____
• cocaine?	_____	_____	_____
• hallucinogens (LSD, angel dust, etc.)	_____	_____	_____
• stimulants (uppers)	_____	_____	_____
• depressants (downers)	_____	_____	_____
• narcotics (heroin, morphine, opium, etc.)	_____	_____	_____

Conclusion

1. Do you feel that your sleep or daytime alertness is abnormal?

2. What is your personal interpretation as to why you have your particular sleep/wake problem? Please describe:

Please check through the questionnaire to see if you have answered all the questions.