OCEAN SLEEP MEDICINE

11 Mareblu, Ste. 200, Aliso Viejo, CA 92656
Phone: (949)446-8990 Fax: (949) 446-8535
Diagnostic Testing & Treatment for Sleep Disorders

ADULT SLEEP QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Sex: _____ Date of birth: _____

Address: _____
Street *City* *State* *Zip Code)*

Email: _____ Phone: _____

REFERRING PHYSICIAN

Name: _____ Phone: _____ Fax: _____

PRIMARY INSURANCE

Insurance Name: _____ IPA/Medical Group: _____

Subscriber ID: _____

Insurance Type:

☐ HMO ☐ MCAL ☐ MCAL HMO ☐ CCS ☐ PPO
☐ EPO ☐ POS ☐ Other: _____

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Name: _____ IPA/Medical Group: _____

Subscriber ID: _____

Insurance Type:

☐ HMO ☐ MCAL ☐ MCAL HMO ☐ CCS ☐ PPO
☐ EPO ☐ POS ☐ Other: _____

PRIMARY SLEEP COMPLAINTS

☐ Trouble falling asleep ☐ Trouble remaining asleep ☐ Excessive sleepiness during the day
☐ Snoring
☐ Unwanted behaviors during sleep, such as _____
☐ Other, explain: _____
How long? _____

PRIOR SLEEP DISORDER DIAGNOSIS OR STUDIES

☐ I have a prior sleep diagnosis of _____

Prior sleep studies (where, when) _____

I am currently prescribed ☐ CPAP or ☐ Bilevel pressure. Settings _____

Oxygen during the ☐ day or ☐ night _____ liters per minute.

☐ Yes ☐ No I have had surgery for a sleep disorder ☐ UPPP ☐ Tonsillectomy.

☐ Other: _____

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

SLEEP PATTERNS

Typical bedtime: _____ weekday _____ weekend

Typical awakening time: _____ weekday _____ weekend

Typical hours in bed: _____ hours.

Typical hours of sleep: _____ hours.

Typical amount of time it takes to fall asleep: _____ hours

Typical number of awakenings per night: _____

Time it takes to fall back asleep after awakening: _____ hours

☐ Yes ☐ No My sleep pattern is irregular.

☐ Yes ☐ No I awaken early in the morning still tired but unable to return to sleep.

SLEEP ENVIRONMENT HABITS

Typical sleep position(s): ☐ back ☐ side stomach ☐ head elevated ☐ in a chair

☐ I sleep alone. ☐ I share a bed with someone.

My bedroom is: ☐ comfortable ☐ noisy ☐ too warm ☐ too cold

☐ Yes ☐ No I have pets in the bedroom.

☐ Yes ☐ No watch TV in bed prior to sleep.

☐ Yes ☐ No I read in bed prior to sleep.

☐ Yes ☐ No I work or study in bed.

☐ Yes ☐ No I drink alcohol prior to bedtime.

☐ Yes ☐ No I smoke prior to bedtime or when I awaken during the night.

☐ Yes ☐ No I eat a snack at bedtime.

☐ Yes ☐ No I eat if I awaken during the night.

BREATHING

☐ Yes ☐ No I have been told that I snore ☐ loudly.

☐ Yes ☐ No I have been told that I stop breathing while asleep.

☐ 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 awaken at night choking or gasping for air.

☐ Yes ☐ No I awaken short of breath.

☐ Yes ☐ No I have trouble breathing when 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.

DAYTIME SLEEPINESS

☐ Yes ☐ No I often feel drowsy during the day, more than I expect is normal.

☐ Yes ☐ No I feel unrefreshed or tired in the morning despite sleeping at night.

☐ Yes ☐ No I take I daytime naps. How many? _____

☐ Yes ☐ No I have uncontrollable urges to fall asleep during the day.

☐ Yes ☐ No I have experienced lapses in time or blackouts.

☐ Yes ☐ No I have fallen asleep while driving.

☐ Yes ☐ No I performed poorly in school or work because of sleepiness.

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate the most appropriate number for each situation.

Please mark "✓" as appropriate:	Would **never** doze	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing
	0	1	2	3
1. Sitting and reading	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting, inactive in a public place (e.g., a theater or meeting)	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6. Sitting and talking with someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐
			TOTAL SCORE:	**0**

RLS

☐ Yes ☐ No I kick or jerk my legs excessively during sleep. ☐ This bothers my bed partner.

☐ Yes ☐ No I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.

☐ Yes ☐ No I experience an inability to keep my leg still prior to falling asleep.

☐ Yes ☐ No I experience the feeling of restlessness in my legs at night.

☐ Yes ☐ No I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise.

☐ Yes ☐ No I experience an inability to move while falling asleep or when 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.

PARASOMNIAS

☐ Yes ☐ No I act on 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.

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 evening.

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

☐ Yes ☐ No I awaken alert in the morning earlier than it is time 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 bedwetting (enuresis).

INSOMNIA

☐ Yes ☐ No I have trouble falling asleep.

☐ Yes ☐ No Thoughts start racing through my mind when I try to fall asleep.

☐ Yes ☐ No I have trouble remaining asleep.

☐ Yes ☐ No I awaken frequently during the night.

☐ Yes ☐ No I have difficulty returning to sleep if I awaken during the night.

HABITS

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

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

☐ Yes ☐ No I drink caffeinated beverages during the day _____ cups/bottles/cans

☐ tea ☐ coffee ☐ soda per day

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment status: ☐ Employed: Occupation _____

☐ Unemployed ☐ Disabled ☐ Student ☐ Retired

☐ Yes ☐ No I regularly work night shifts.

☐ Yes ☐ No I work rotating shifts, including nights shiftwork.

PAST MEDICAL HISTORY

☐ Hypertension ☐ Coronary artery disease ☐ Congestive heart failure ☐ Stroke

☐ Seizures ☐ COPD/asthma ☐ Diabetes ☐ Cancer ☐ Thyroid problems

☐ Depression or anxiety ☐ Alcoholism or chemical dependency ☐ Sinus disease

☐ Allergic rhinitis/nasal congestion ☐ Nasal fracture ☐ Reflux (GERD)

☐ Stomach or colon problems ☐ Fibromyalgia ☐ Back or joint problems (arthritis)

☐ Other: _____

Female: ☐ Premenstrual syndrome ☐ Menopause

Male: ☐ Prostate problems ☐ Erectile dysfunction

Prior surgeries: _____

Weight change during the past year ☐ gained _____ pounds ☐ lost _____ pounds

CURRENT MEDICATIONS (OR ☐ LISTED ON SEPARATE SHEET)

Medication	Dose	Times Per Day

Allergies: _____

FAMILY HISTORY

Has an immediate blood relative had any of the following?

☐ Obstructive sleep apnea ☐ Narcolepsy ☐ Other sleep disorders? _____

_____

STOP BANG QUESTIONNAIRE

Please answer the following questions below to determine if you might be at risk for Obstructive Sleep Apnea

Do you snore loudly *(louder than talking or loud enough to be heard through closed doors)*? ☐ Yes ☐ No

Do you often feel tired, fatigued, or sleepy during daytime? ☐ Yes ☐ No

Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No

Body Mass Index Calculator: *Height:* _____*Inches* *Weight:* _____*lbs*

BMI = _____

Is your BMI more than 35Kg/m^2 ☐ Yes ☐ No

Are you more than 50 years old? ☐ Yes ☐ No

Is your neck circumference >16 inches (40cm)? ☐ Yes ☐ No

Is your neck size larger than 43cm if male or 41cm if female? ☐ Yes ☐ No

Hint: *To obtain an accurate measurement, measure around your Adams apple OR answer Yes if your collar size is greater than XL.*

Is your gender male? ☐ Yes ☐ No

SCORE: 0_____

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ-10)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired.

In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Directions

Please put a " ✓ " in the box for your answer to each question. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

Please mark " ✓ " as appropriate:	Yes, extreme	Yes, moderate	Yes, a little	No
	1	2	3	4
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐	☐	☐	☐
2. Do you generally have difficulty remembering things, because you are sleepy or tired?	☐	☐	☐	☐
3. Do you have difficulty finishing a meal because you become sleepy or tired?	☐	☐	☐	☐
4. Do you have difficulty working on a hobby (for example, sewing, collecting, gardening) because you are sleepy or tired?	☐	☐	☐	☐
5. Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	☐	☐	☐	☐
6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐
7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐
8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?	☐	☐	☐	☐
9. Do you have difficulty taking care of financial affairs and doing paperwork (for example, writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	☐	☐	☐	☐
10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	☐	☐	☐	☐
			TOTAL SCORE	0