EAST TEXAS
EAR NOSE & THROAT

ph 903-291-6300 • fx 903-291-6305
709 Hollybrook Drive, Suite 5605 • Longview, Texas 75605
www.easttexasent.com

Pre-Sleep Questionnaire

Patient Name: _____ **Date:** _____
Last First Middle

Date of Birth: _____ Neck Size: _____ Current Height: _____ Current weight: _____

Weight Changes: Within last three years: GAINED _____ (pounds); LOST _____ (pounds)

Have you ever had a Sleep Study? □ yes □ no When? _____ Where? _____

What was the outcome of the study? _____

Chief Complaint

Check any of the following that apply:

- □ Loud snoring
- □ Breathing or snoring stops for brief periods in my sleep
- □ Awaken gasping for breath
- □ Do not feel restored when I awaken
- □ Difficulty falling asleep
- □ Difficulty remaining asleep
- □ Become sleepy during the day while (please circle all that apply)
  - □ sitting □ talking □ watching T.V.
  - □ riding □ theaters □ driving □ standing

My MAIN sleep problem has bothered me:

- [ ] 1 to 2 years
- [ ] longer than 2 years
- [ ] several months to 12 months
- [ ] within the last 3 months
- [ ] within the last month

Sleep Treatment

I was previously diagnosed with:

□ Sleep apnea □ Restless legs syndrome □ Narcolepsy □ Periodic limb movements □ Insomnia

If yes to any of the above please explain: When? _____ Where? _____

Treatment: _____

Medical History

Please check if you have had any of the following:

- □ Oral Appliance □ CPAP or BiPAP Treatment - Setting of _____cmH_20
- □ Supplemental Oxygen with _____ liters/minute approx. _____ hours per day or night (circle one)
- □ Diabetes □ Depression □ Seizures □ Parkinson's disease
- □ High blood pressure □ Reflux □ Thyroid condition □ Asthma / Emphysema
- □ Fibromyalgia □ Anxiety □ Stroke □ Head injury or brain surgery
- □ Heart disease - type: _____ □ Uvulopalatopharyngoplasty

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□ Tonsillectomy □ Adenoidectomy □ Laser or other procedure on uvula

□ Sinus, deviated septum or turbinate reduction □ Mandibular surgery

□ Pain which disrupts sleep. The typical location(s) for this pain is/are:

□ Headaches □ Neck □ Back □ Chest □ Limb □ Abdominal □ Pelvic □ Joint (arthritis)

□ Other medical problems which may affect sleep:_____

Symptoms During Sleep

Indicate if you experience the following symptoms when trying to sleep and after awakening:

Yes	Symptoms
	Memory impairment
	Inability to concentrate
	Fatigue
	Anxiety
	Depression
	Awaken with sore throat and hoarse
	Morning headaches
	Awaken with a dry mouth
	Feeling tired and sleepy during the daytime
	Sudden paralysis or feel your body go limp when you are angry or excited
	Frequent arousals from sleep and cannot return to sleep
	Wakes for unknown reasons
	Restless sleep
	Confusion after awakening
	Creeping or crawling sensation in your legs before falling asleep
	Legs or arms jerking during sleep
	Sleep talking
	Sleep walking
	Nightmares
	Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
	Frequent urination disrupting sleep
	Teeth grinding
	Wheezing or cough disrupting sleep
	Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
	Shortness of breath disrupting sleep

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Social History

Do you smoke? □ yes □ no Did you previously smoke? □ yes □ no When did you quit? _____

How many years of smoking? _____ How much per day? _____

Do you drink alcohol? □ yes □ no How much? _____ drinks per (day/week/month) (please circle)

How much caffeinated coffee, tea or cola do you drink daily? _____

Environment

Is your bedroom (loud/quiet) and (light/dark)? (please circle)

Is your mattress (soft/hard/just right)? (please circle)

Do you go to sleep with the television on? □ yes □ no

Is your sleep disturbed because of your bed partner or others in your household? □ yes □ no

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you have not done some of these activities recently, please try to estimate how you would typically respond. Use the following scale 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

Situation	*Chance of Dozing*			
Sitting and reading ……..	**0**	**1**	**2**	**3**
Watching TV ……	**0**	**1**	**2**	**3**
Sitting, inactive, in a public place (e.g., a theater or a meeting) …….	**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 circumstances permit ……	**0**	**1**	**2**	**3**
Sitting and talking with 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	_____			

Medication

Do you take anything to help you sleep? □ Yes □ No If so, what do you take?_____

How often?_____

Are you allergic to certain things touching your skin? □ Yes □ No What?_____

_____

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DRUG ALLERGIES	TYPE OF REACTION

Please list all current medications, including all vitamins, herbals, over-the-counters, and prescriptions

MEDICATION NAME AND STRENGTH	PRESCRIBED (RX) or OVER THE COUNTER (OTC)	DOSAGE	FREQUENCY
	☐ RX ☐ OTC		
	☐ RX ☐ OTC		
	☐ RX ☐ OTC		
	☐ RX ☐ OTC		
	☐ RX ☐ OTC		
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If this test determines that you have a sleep disorder, many times you will have a trial of CPAP (continuous positive airway pressure) at home for treatment. If this is ordered for you, it is usually a covered benefit through your insurance provider. If you have a preference of the medical equipment dealer to use, please list it here, _____, or else East Texas Ear, Nose, & Throat will select a provider that is in your network for your insurance.

Please sign and date below to confirm that you have answered these questions to the best of your knowledge and that you understand that this information is regarded as confidential and is only released to East Texas Ear, Nose, & Throat personnel and physicians involved in making your diagnosis.

_____ _____

Signature of patient or caregiver Date