CAPA

Sleep Questionnaire

New patient

Capitol Area Pulmonary Associates
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Name:		Date of Birth:		Age:		Sex:	

Today's Date:		Height:	Inches	Weight:	Lbs

Weight 1 year ago:	Lbs	Weight 5 years ago:	Lbs

What is your main sleep related problem?	
How long have you had this problem?	

SLEEP SCHEDULE (*Please provide the following information, circle answer where appropriate)*

What time do you go to bed on WEEKDAYS? _____ AM or PM WEEKENDS? _____ AM or PM

What time do you wake up on WEEKDAYS? _____ AM or PM WEEKENDS? _____ AM or PM

Do you **nap**? YES NO

How **often** do you **nap**? _____ Times per week

How **long** are the **naps**? _____ Minutes

Do you **awaken refreshed**? YES NO

Are you a **shift worker**? YES NO If yes, what times do you work? _____

SNORING / BREATHING HISTORY (*Please circle appropriate answer)*

Do you **snore**?	Do Not Know	Sometimes	Yes	No
Does your **sleep position** affect your **snoring**?			Yes	No
Have you awakened **choking** or short of **breath**?			Yes	No
Has anyone noticed that you **stop breathing** while asleep?			Yes	No
Do you have morning **headaches**?			Yes	No
Do you awaken more than twice to **urinate** during the night?			Yes	No
Do you awaken **refreshed** in the morning			Yes	No
Do you awaken with an **acid** or **sour taste** in your mouth			Yes	No
Do you have **difficulty** sleeping on your **back**?			Yes	No

SLEEP HISTORY *(please circle appropriate answer)*

Do you have **difficulty falling asleep**?	Yes	No
Do you have **difficulty staying asleep**?	Yes	No
Do you **wake up too early** and cannot get back to sleep?	Yes	No
Do you have thoughts **racing through** your mind that make it difficult to sleep?	Yes	No
Have you fallen **asleep unexpectedly**?	Yes	No
Have you ever fallen **asleep** while **driving drowsy**?	Yes	No
Have you ever had a motor **vehicular crash** due to **drowsy driving**?	Yes	No
Have you experienced **"sleep attacks**" (a sudden irresistible urge to sleep)?	Yes	No
Have you experienced **sudden muscle weakness** in response to emotions?	Yes	No
Have you experienced **an inability to move while falling asleep** or waking up?	Yes	No
Have you experienced **dreamlike images** or sounds while falling asleep or waking up?	Yes	No
Do you **kick or jerk** your arms or legs during sleep?	Yes	No
Have you experienced an **urge to move** your legs accompanied by an **uncomfortable sensation**?	Yes	No
Do you have an urge to move your **legs** that **worsens with rest or inactivity** like lying down or sitting?	Yes	No
Do you have an urge to move your **legs** that is **relieved by walking or stretching**?	Yes	No
Do you have an urge to move and an unpleasant sensation **in your legs** that occurs **only at night**?	Yes	No
Do you **talk** in your sleep?	Yes	No
Do you have **nightmares**?	Yes	No
Have you ever **acted out** your **dreams**?	Yes	No
Do you **grind** your teeth?	Yes	No

MEDICAL/SURGICAL HISTORY (*please circle answer and fill in the blank where appropriate)*

Have you ever had a **sleep study** in the **past**? YES NO

When? _____ Where? _____

Do you **use** home **CPAP or BIPAP**? YES NO

Who prescribed? _____ What pressure setting? _____

Do you use home **oxygen**? YES NO

What liter/flow setting? _____

Do you have a **pacemaker/defibrillator with pacemaker**? YES NO

Have you ever had a **tonsillectomy**? YES NO

Have you ever had sinus or **nasal surgery**? YES NO

Have you ever **broken your nose**? YES NO

Have you ever had any type of **head injury**? YES NO

Have you had **surgery** to promote **weight loss**? YES NO When? _____

Please check the appropriate box if you have a history of any to the following health problems.

☐ Hypertension
☐ Heart Attack
☐ Congestive Heart Failure
☐ Sexual dysfunction/ loss of libido
☐ Diabetes
☐ Lung problems/ COPD/Asthma
☐ Stroke/ TIA
☐ Acid Reflux (heartburn)
☐ Arthritis
☐ Fibromyalgia
☐ Cardiac Arrhythmias
☐ Depression
☐ Anxiety
☐ Seizures
☐ Dementia
☐ Claustrophobia

Other_____

_____

FAMILY HISTORY *Does any member of your family have the following?*

Sleep Apnea?	YES	NO	Relationship	_____
Narcolepsy?	YES	NO	Relationship	_____
Seizure disorder?	YES	NO	Relationship	_____
Depression?	YES	NO	Relationship	_____
Hypertension?	YES	NO	Relationship	_____
Stroke?	YES	NO	Relationship	_____
Heart Disease?	YES	NO	Relationship	_____
Psychiatric illness?	YES	NO	Relationship	_____
Other Disorder?			Relationship	_____

SOCIAL HISTORY *(please circle answer and fill in the blank where appropriate)*

What is your occupation? _____ If retired, when? _____

Previous jobs held _____

Marital status_____ Do you share a bed with someone? YES NO

Do you smoke? YES NO Packs per day? _____ how long? _____

Have you smoked in the past? YES NO Packs per day? _____ how long? _____
If you quit, when?_____

Do you drink beer, wine, or liquor? YES NO How much? _____ How long? _____

REVIEW OF SYSTEMS

(Please check where appropriate if you have had any of these symptoms in the last 12 months).

- ☐ Frequent headaches
- ☐ Fainting or passing out
- ☐ Difficulty understanding instructions
- ☐ Difficulty giving instructions
- ☐ Difficulty following instructions
- ☐ Decreased short term memory
- ☐ Difficulty organizing thoughts
- ☐ Difficulty planning activities/trips
- ☐ Sudden loss of Vision, strength
- ☐ Hearing loss or ringing in ears
- ☐ Nosebleeds
- ☐ Cough for more than 2 weeks
- ☐ Coughing up blood
- ☐ Shortness of breath/wheezing
- ☐ Swelling in feet or ankles
- ☐ Chest pain or heaviness
- ☐ Irregular heartbeat
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Frequent heartburn
- ☐ Frequent constipation
- ☐ Frequent diarrhea
- ☐ Rectal bleeding/black stools
- ☐ Difficulty urinating/incontinence
- ☐ Blood in urine
- ☐ Urinating more than 2 times a night
- ☐ Pain in bones or joints
- ☐ Unusual bruising or bleeding
- ☐ Convulsions
- ☐ Change in wart, mole or skin growth
- ☐ Weight loss of more than 5-10 lb
- ☐ Other (describe) _____

_____

_____

MEDICATIONS (please list, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	#Times/Day

Allergies (please list) **____ NO KNOWN DRUG ALLERGIES**

Yes	**No**	**Do you snore loudly (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?**
Yes	**No**	**Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?**
Yes	**No**	**Has anyone observed you stop breathing or choking/gasping during your sleep?**
Yes	**No**	**Do you have or are being treated for high blood pressure?**
Yes	**No**	**Body mass index more than 35 kg/m2?**
Yes	**No**	**Age older than 50 years old?**
Yes	**No**	**Is your shirt collar 16 inches or larger?**
Yes	**No**	**Gender (biologic sex) = Male?**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Please circle the most appropriate answer using the following scale.

0 = never	1 = occasionally	2 = often	3 = usually

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
At a public place like a theater or meeting	0	1	2	3
While a passenger in a car for one hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting down after lunch	0	1	2	3
Stopped at a stoplight	0	1	2	3

Total score out of 24:_____*(please add)*

Signature: _____ Date: _____

Please circle one of the following (Patient/guardian/caretaker)