Sleep Medicine Department
888 South King St.
Honolulu, HI 96814
P:(808) 522-4448 | F:(808) 522-3048

HAWAIʻI PACIFIC HEALTH | STRAUB MEDICAL CENTER
CREATING A HEALTHIER HAWAIʻI

Please fax the completed questionnaire to 522-3048 or bring to your appointment.

SLEEP MEDICINE INITIAL CONSULTATION QUESTIONNAIRE

Today's Date:_____

Name: _____

Date of Birth: _____

Marital Status: _____Does your partner sleep in the same bed as you? ❑ Yes ❑ No

Employment Status: _____

Occupation: _____Have you had an accident on the job due to falling asleep? ❑ Yes ❑ No

1. **In which position do you sleep**: _____ back _____ side _____ stomach _____ upright

2. **Are you able to lie flat to sleep at night**? ❑ Yes ❑ No

3. **Please put an X in the box that best applies to you.**

	Never	Rarely	Sometimes	Often	Always
A. Snore loudly?	☐	☐	☐	☐	☐
B. Wake up choking or gasping for breath?	☐	☐	☐	☐	☐
C. Stop breathing or hold your breath during sleep?	☐	☐	☐	☐	☐
D. Wake up feeling refreshed?	☐	☐	☐	☐	☐
E. Wake up with a headache?	☐	☐	☐	☐	☐
F. Feel sleepy during the day?	☐	☐	☐	☐	☐
G. Find it hard to concentrate on what you are doing?	☐	☐	☐	☐	☐
H. Tend to be forgetful during the day?	☐	☐	☐	☐	☐
I. Feel irritable, agitated or down?	☐	☐	☐	☐	☐

4. **Have you had a sleep study in the past?** ❑ Yes ❑ No

5. **Have you regularly taken any kind of medicine to stay awake?** ❑ Yes ❑ No
   If yes, what kind of medication did you take to stay awake?

   ❑ Over the counter stimulant ❑ Prescription stimulant ❑ Other _____

6. **Have you regularly taken any kind of medicine to help you sleep?** ❑ Yes ❑ No
   If yes, what kind of medication did you take to sleep?

   ❑ Ambein (zolpidem) ❑ Lunesta (eszopiclone) ❑ Benadryl (diphenhydramine) ❑ Melatonin

   ❑ Benzodiazepine class (Xanax, Ativan, Valium, Restoril) ❑ Trazodone ❑ Other _____

   For how long have you been on this medication?_____

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7. **Caffeine and alcohol use <u>per day</u>:**

	None	1-3 cups	4+ cups
Coffee	☐	☐	☐
Tea	☐	☐	☐
Soda (with caffeine)	☐	☐	☐
Beer/Wine/Liquor	☐	☐	☐

8. **Please put an X in the box that best applies to you.**

	Never	Rarely	Sometimes	Often	Always
A. When you try to relax in the evening or sleep at night, do your legs feel restless and moving or walking around makes them feel comfortable?	☐	☐	☐	☐	☐
B. Do you kick your legs at night?	☐	☐	☐	☐	☐
C. Do you have the sudden urge to fall asleep outside of your normal bedtime?	☐	☐	☐	☐	☐
D. Do you wake up unable to move your arms or legs?	☐	☐	☐	☐	☐
E. Do your muscles feel weak when you laugh or get upset?	☐	☐	☐	☐	☐
F. Do you see images when waking up or falling asleep, as if you were dreaming?	☐	☐	☐	☐	☐
G. Do you move around a lot in bed?	☐	☐	☐	☐	☐
H. Do you have nightmares?	☐	☐	☐	☐	☐
I. Do you grind your teeth at night? If yes: Do you use a mouth guard? ❑ Yes ❑ No	☐	☐	☐	☐	☐
J. Do you feel anxious about your sleep?	☐	☐	☐	☐	☐
K. Do you have pain or discomfort at night?	☐	☐	☐	☐	☐
L. Do you wake up with your heart pounding/racing?	☐	☐	☐	☐	☐
M. Do you have stomach pain or heart burn at night?	☐	☐	☐	☐	☐
N. Have you been told that you have abnormal movements at night (sleep walking/talking/eating)?	☐	☐	☐	☐	☐
O. Have you been told that you act out your dreams (bicycle legs, punch, fallen out of bed?	☐	☐	☐	☐	☐

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9. **Medical History**

Please check if you have ever had any of the following conditions:

- ❑ Asthma/Bronchitis
- ❑ Atrial Fibrillation
- ❑ Chronic Pain
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ COPD or Emphysema
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Epilepsy, seizures
- ❑ Frequent headaches
- ❑ GERD (heartburn)
- ❑ High blood pressure
- ❑ Hypothyroidism
- ❑ Nasal allergies/congestion
- ❑ Nocturia (urinating at night)
- ❑ Overweight or obese
- ❑ Panic or anxiety attacks
- ❑ Problems with alcohol or drugs
- ❑ Stroke
- ❑ Sexual function problems
- ❑ Supplemental oxygen use _____ liters
- ❑ Other _____

10. **Surgical Sleep History**

Please check if you have ever had any of the following surgery:

- ❑ Correction of deviated septum
- ❑ Tonsillectomy and adenoidectomy
- ❑ Turbinate reduction
- ❑ Uvulopalatopharyngoplasty (UPPP)
- ❑ Tracheostomy
- ❑ Weight loss surgery
- ❑ Maxillomandibular osteotomy (MMO) and advancement (MMA)

11. **Does anyone in your family have the following conditions?**

- ❑ Restless leg syndrome
- ❑ Obstructive sleep apnea
- ❑ Insomnia
- ❑ Parasomnia (sleepwalking/talking/eating)

12. **When do you feel the most awake?**

- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ Nighttime

13. **How many times do you nap a week?**

- ❑ Never
- ❑ 1-3 times
- ❑ 4-5 times
- ❑ Daily

Do you feel refreshed after napping? ❑ Yes ❑ No What time do you nap? _____PM/AM.

How long do you nap? _____ min(s)/hour(s)

14. **On an average how many hours do you sleep a night?** _____ hours

15. **Do you feel this is enough sleep for you?** ❑ Yes ❑ No

16. **Sleep Schedule:**

On *WEEKDAYS* I go to bed at _____PM/AM and get out of bed at _____ AM/PM.

On *WEEKENDS* I go to bed at _____PM/AM and get out of bed at _____ AM/PM.

17. **On average it takes me the following amount of time to fall asleep:**

- ❑ <5 minutes
- ❑ 5-10 minutes
- ❑ 10-20 minutes
- ❑ 20-30 minutes
- ❑ 30-60minutes
- ❑ More than 60 minutes

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18. **Nighttime awakenings:**
I wake up _____ times a night for _____ minutes before falling back to sleep.

I wake up in the middle of the night to _____

19. **Do you do other activities (i.e. read a book, watch TV, go on my phone) while in bed?** ❑ Yes ❑ No

List the activities:_____

_____

20. **Have you ever or do you currently work different shifts throughout the day?** ❑ Yes ❑ No

21. **The follow best describes my exercise level:**

❑ Little or no exercise ❑ Exercise at least 3x a week ❑ Exercise at least 6-7x a week

22. **I have had an accident or near accident while driving due to falling asleep**: ❑ Yes ❑ No

23. **In the past 1-2 weeks have you experienced any of the following:**

☐ General: fever or chills, recent illness

☐ Eyes: blurry vision, change in vision

☐ Lung: cough, shortness of breath

☐ Heart: chest pain, irregular heart beat

☐ Stomach/Intestines: abdominal pain, nausea or vomiting, diarrhea, constipation

☐ Urinary: trouble urinating, burning with urination

☐ Musculoskeletal: joint pain or swelling, muscle aches

☐ Psychological: depression, anxiety

☐ Blood: easy bruising or excessive bleeding

☐ Skin: itchiness or rashes

☐ None of the above applies to me.

Submit Form