SLEEP CENTER OF YUMA
ASHVIN K SHAH MD, FCCP, PC
FAX: 928-726-6306

2110 W. 24TH STREET
YUMA, AZ. 85364
PHONE: 928-344-1891

SLEEP QUESTIONNAIRE NAME _____ /DOB: _____

BED PREP HABITS----------

DO YOU PERFORM ANY OF THE FOLLOWING IN BED? NONE / READ/ WATCH TV / WORRY/ EAT/ WRITE/ARGUE

1. What is your reason for visiting the Sleep Center Today?_____
2. What is your primary sleep complaint? _____
3. Have you ever been diagnosed with ANY type of sleep disorder? **YES/ NO-** If so, how long ago?_____
   what and where was the diagnosis made?_____
4. Have any family members been diagnosed with a sleep disorder? YES / NO - Who?_____
5. Describe the type of work you do: _____
6. Do you have a regular sleep partner? YES / NO
7. Any recent weight gain YES / NO - If so, how much?_____
7. Have you ever fallen asleep while driving a car? YES / NO
8. Have you ever had hallucinations or exceptionally vivid dreams while falling asleep? YES / NO
9. Have you ever felt sudden muscle weakness when laughing, angry, or surprised? YES / NO
10. Have you ever felt paralyzed or unable to move just when falling asleep or waking up? YES NO
11. Do you snore? NEVER / OCCASIONALLY / FREQUENTLY / ALWAYS / UNSURE
    If you snore, rate yourself on a scale from 1-10 (10 is loudest)_____,
    How would your sleeping partner rate your snoring with the same scale? _____ N/A
    What position affects your snoring (if any)? BACK / RIGHT SIDE / LEFT SIDE / STOMACH
12. Do you wake up with any of the following?

COUGHING / CHOKING / CONFUSED / RAPID HEARTBEAT/ HEADACHE / ACID TASTE / DRY MOUTH / SORE THROAT

PROBLEMS DURING SLEEP----------

1. Do you have problems falling asleep due to any of the following?
   Trouble Relaxing / Pain or Discomfort / Racing Thoughts
2. Does waking too early and not going back to sleep bother you? YES / NO / SOMETIMES
3. Do you have prolonged periods when you are awake and can't get back to sleep? YES / NO / SOMETIMES
4. Do you frequently check the clock when you are unable to sleep? YES / NO / SOMETIMES
5. Has your mood, or thought process changed recently? YES / NO / SOMETIMES
6. Within the last year- has depression, anxiety or stress interfered with you sleep? YES / NO / SOMETIMES
7. Do you have nightmares? YES / NO - Any history of bed wetting? YES / NO - Do you sleep walk? YES / NO
8. Do you grind your teeth? YES / NO - Do you use a mouth device? YES / NO
9. Are your covers messy in the morning? YES / NO - Do you thrash in your sleep? YES / NO
10. Have you ever kicked or hit you bed partner in your sleep? YES / NO
11. Do you have episodes of flailing your arms/ kicking your legs/ screaming in your sleep? YES / NO
    If so, do you recall dreaming during the episode(s)? YES / NO - Or become confused? YES / NO
    Do you remember the episode(s) in the morning? YES / NO
12. Has anyone ever said you stop breathing in your sleep? YES / NO

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NAME_____ **DOB:** _____

SLEEP TIMES

NORMAL BEDTIME_____ NORMAL WAKE TIME_____ BEDTIME ON NON-WORKDAYS_____
WAKE TIME ON NON-WORKDAYS_____ HOW MANY HOURS DO YOU NORMALLY SLEEP_____
HOW LONG DOES IT TAKE YOU TO FALL ASLEEP_____ HOW OFTEN DO YOU GET UP AT NIGHT_____
HOW LONG DOES IT TAKE YOU TO GET BACK TO SLEEP_____ WHAT WAKES YOU_____
DO YOU HAVE A HARD TIME GETTING BACK TO SLEEP_____ DO YOU HAVE MEMORY PROBLEMS_____
DO YOU NAP? YES / NO -IF SO, ARE YOUR NAPS REFRESHING? YES / NO
ARE YOU SLEEPY DURING THE DAY? YES / NO

SLEEP DISTURBANCES----------

My sleep is frequently disturbed by the following *(CIRCLE all that apply):*

NONE / CHILDREN / BED PARTNER / PETS / INDIGESTION / PAIN / LEG DISCOMFORT / HEADACHES / NAUSEA / CHOKING-GASPING FOR AIR / SINUS OR COLD SYMPTOMS/ SHORTNESS OF BREATH/ ASTHMA/ FRIGHTENING DREAMS / NEED TO URINATE / HUNGER / COUGH / THIRST / NOISE / STRESS

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?

Use scale to choose the most appropriate #: 0= never / 1= slight chance / 2= moderate chance /3= high chance

SITUATION	**CHANCE OF DOZING OFF**			
Sitting and reading	0	1	2	3
Sitting, inactive, in a public place (theater, meeting.)	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Watching T.V.	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
passenger in a car for about an hour without a break	0	1	2	3

HABITS----------

Do you smoke? YES / NO - If so, how many per day?_____
Do you drink alcohol? YES / NO / RARELY / If so, how many on (average) work days? _____ Weekends? _____
Do you drink caffiene? YES / NO- If so, what kind: TEA / SODA / COFFEE / ENERGY DRINKS
How many cups per day? _____

MEDICAL HISTORY----------

CIRCLE ALL THAT APPLY:

NONE / HIGH BLOOD PRESSURE / CLAUSTROPHOBIA / DEPRESSION / DIABETES / HEART DISEASE / LUNG DISEASE / GERD / NASAL OR SINUS PROBLEMS / OTHER THROAT OR NOSE SURGERY / PANIC ATTACKS / SEIZURES / STROKE / THYROID DISEASE / OTHER:_____

HAVE YOU EVER HAD A SURGERY OF SLEEP APNEA? YES / NO, If so, when?_____