

Alabama Sleep Clinic Questionnaire

NAME _____ AGE _____ MARITAL STATUS _____
 Primary Care Physician _____ Referring Physician _____ Height _____
 Occupation _____ What shift? (circle one) 1st 2nd or 3rd

Briefly describe the reason for your visit:

Current Medication	Strength	When is it taken?	Allergies

Family history of sleep disorders (including restless legs)

Family member	Type of disorder	Treatment

Social History

Substance	How much?	How often?
Tobacco use		
Alcohol use		
Caffeine		

Medical History

Allergies (seasonal)	Fibromyalgia / Chronic pain	Irritable bowel syndrome
Anemia	GERD (acid reflux)	Migraines
Asthma	Hepatitis, type: _____	Multiple Sclerosis
Atrial Fibrillation	High blood pressure	Obesity
Cancer, type: _____	High cholesterol	RLS (Restless legs syndrome)
Congestive heart failure	History of heart attack	Seizures
COPD	History of head trauma	Thyroid problems
Coronary artery disease	History of sleep apnea	Other: _____
Diabetes	History of stroke	Other: _____

Psychiatric Disorder

Depression	Anxiety	Other: _____
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Previous Sleep Studies

Date of study	Location of study	Treatment

Past Surgeries

Tonsillectomy / Adenoidectomy	Deviated Septum repair
UPPP or UP3	Other: _____

Sleep Schedule (Please answer each question for you usual night time routine)

Time you enter bedroom?	How many awakenings do you have?
Time you attempt sleep?	How long are the awakenings?
Time it takes to fall asleep?	What causes your awakenings?
Number of awakenings to urinate?	Time you actually get out of bed?
Time you wake up?	Do you wake to an alarm clock?
How do you feel when you awaken?	How many hours of sleep per night do you average?

Naps

Do you take naps?	How long are the naps? (in minutes)
If so, How many naps per week?	How do you feel upon awakening?

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Section I.					
Do you snore? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE					
If so, do you do so on your ... <input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> All positions.					
What percent of time do you spend sleeping in each position?					
Back	%	Side	%	Stomach	%
Recliner	%				
Questions	Y	N	Question	Y	N
Stop breathing when sleeping?			Decreased sex drive?		
Gasping/choking noises when sleeping?			Menopausal? (female only)		
Excessive daytime sleepiness?			Restless sleep (knock covers off)?		
Urination during sleep? # of episodes _____			Drowsy driving / near misses?		
Headaches upon awakening?			Weight gain?		
Poor concentration?			lbs in _____ months/ years		
Poor memory?			Weight gain/loss was intentional?		
How long have you experienced these problems? _____					
Do you have difficulty initiating or maintaining sleep?					
Do your legs bother you? Such as a restlessness or an irresistible urge to move them?					
Do you hallucinate?					
Do you act out your dreams?					
Do you experience total body paralysis when waking or falling asleep?					
Do you have loss of muscle strength during intense emotion?					
ROS					
Symptoms	YES	NO	Symptoms	YES	NO
History of head trauma			Difficulty swallowing		
Weight gain			Reflux/heartburn		
Change in hearing			Urgency to urinate		
Change in vision			Frequent urination		
Nasal congestion			Joint Pain		
Recurrent sinus infections			Muscle Pain		
Seasonal allergies			Swelling of extremities		
Palpitations (feel heart beat)			Headaches		
Fast heart beat			Tingling of extremities		
Cough			Chronic Pain (where? _____)		
Nausea			Excessive thirst		
Vomiting			Intolerance to heat		
Constipation			Intolerance to cold		
Diarrhea			Easy bruising or bleeding		
Pain with swallowing					

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to visualize how they would have affected you.

Situations	CHANCE OF DOZING (circle one) 0= never, 1 = slight change of dozing, 2= moderate chance of dozing and 3 = high chance of dozing.			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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 afternoons when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped in traffic for a few minutes	0	1	2	3
Total				

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