TENNESSEE COMPREHENSIVE LUNG AND SLEEP CENTER
SLEEP QUESTIONNAIRE

Patient Name:_____ Sex:_____ Age:_____ Date:_____

Referring Physician:_____ Family Physician (PCP):_____

Occupation:_____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

Anyone ever told you that you snore? ☐ Yes ☐ No

Is it worse on your back? ☐ Yes ☐ No

Does it disturb anyone? ☐ Yes ☐ No Who?_____

Do you awake yourself snoring? ☐ Yes ☐ No

Has anyone ever noticed if you stop breathing? ☐ Yes ☐ No

Do you gasp or choke while you sleep? ☐ Yes ☐ No

Do you have a dry mouth in the morning? ☐ Yes ☐ No

Do you have morning headaches? ☐ Yes ☐ No

Do you feel sleepy during the daytime? ☐ Yes ☐ No

How many days per week?_____
When did it start?_____

Please rate you chances of falling asleep in the following situations using the scale below.

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High Chance of dozing

____Sitting and reading

____Watching television

____Sitting inactive in a public place

____While a passenger in a car without a break

____Laying down to rest in the afternoon when circumstances permit

____Sitting and talking to someone

____Sitting quietly after lunch

____In a car, while stopped in traffic for a few minutes ***ESS***_____

Ever had a close call or accident when driving because of sleepiness? ☐Yes ☐ No

Do you suffer from memory problems? ☐Yes ☐ No

SLEEP SCHEDULE

On normal workdays: Bedtime:_____a.m./p.m.
Wake up:_____a.m./p.m.

On days off: Bedtime:_____a.m./p.m.
Wake up:_____a.m./p.m.

How long does it take you to fall asleep? _____min. _____ hrs.
Where do you fall asleep? ☐ Bed ☐ Chair ☐ _____
Do you have thoughts racing through your mind when trying to fall asleep ☐Yes ☐ No

Do you awake early in the morning unable to return to sleep? ☐Yes ☐ No

Are you still tired when you awake in the morning? ☐Yes ☐ No

How do you usually awaken, i.e., alarm clock? _____

Approximate total hours of sleep per night: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired
☐ My job requires driving a vehicle ☐ I am a permanent or long-term, third shift worker

☐ I work with dangerous equipment ☐ I am currently a student

☐ I am a shift worker on rotating shifts

Work hours (if applicable) _____
If you don't work, how do you occupy your days? _____

Do you take naps? ☐Yes ☐ No
If yes number of day per wk _____
Do they make you feel refreshed? ☐Yes ☐ No

Do you wake up in the middle of the night? ☐ Yes ☐ No
How many times per night? _____

Do you fall asleep again easily? ☐ Yes ☐ No
How long?_____ mins/hours

SLEEP HYGIENE
Drinks alcohol before going to bed? ☐Yes ☐ No

Do you watch TV in your bedroom? ☐ Yes ☐ No

Do you look at the time when unable to sleep ☐ Yes ☐ No

Do you consume caffeinated beverages/chocolate ☐ Yes ☐ No

SLEEP RELATED BEHAVIOR
Do you have any abnormal sensation in your

legs at night or while sitting? ☐ Yes ☐ No

Does it interfere with sleep? ☐ Yes ☐ No

Ever felt a sudden loss of strength (arms or legs) when you are upset or excited? ☐ Yes ☐ No

Have you ever felt paralyzed when you first wake up or when you are falling asleep? ☐ Yes ☐ No

Have you ever experience vivid or menacing visions while you are falling asleep or awakening? ☐ Yes ☐ No

Do you walk or talk in your sleep? ☐ Yes ☐ No

Do you ever accidentally urinate in bed? ☐ Yes ☐ No

Do you have nightmares? ☐ Yes ☐ No

Do you grind your teeth while asleep? ☐ Yes ☐ No

Medical History

Vital Statistics

Height? ____feet ____inches Weight? _____lbs Neck size:_____ inches

Approximate weight change in the last year? ☐ Yes ☐ No

Pounds: gained _____ Lost_____

Current Medications

Medication	Dose	# Times Per Day	Medication	Dose	# Times Per Day

Allergies:_____

Past Sleep Evaluation and Treatment

Have you had a overnight sleep study? ☐ Yes ☐ No _____yrs ago

Have you had a daytime nap study? ☐ Yes ☐ No _____yrs ago

Do you have a CPAP or BiPAP machine at home? ☐ Yes ☐ No Pressure_____

Have you had surgical treatment for sleep disorder? ☐ Yes ☐ No _____yrs ago

Tried prescription medication for a sleep disorder? ☐ Yes ☐ No

Past Medical History

☐ Hypertension (high blood pressure)
☐ Heart failure
☐ Diabetes
☐ Stroke
☐ Seizures
☐ Depression or severe anxiety
☐ Lung Problems/COPD/asthma
☐ Sinus problems
☐ Thyroid problems
☐ Atrial fibrillation
☐ Reflux
☐ Back or joint pain
☐ Prostate problems
☐ Erectile Dysfunction/impotence

List other past medical problems:

_____ _____
_____ _____
_____ _____

List Surgeries and the year:

_____ _____
_____ _____
_____ _____

New complaints in any area of your body in the **past 12 months**: ☐Yes ☐ No

_____ _____
_____ _____

Family History:

_____ _____
_____ _____
_____ _____

Name:_____

STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb/kg
Age _____
Male/Female
BMI _____

Collar size of shirt: S, M, L, XL, or _____ inches/cm
Neck circumference* _____ cm

1. *S*noring
Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No

2. *T*ired
Do you often feel *t*ired, fatigued, or sleepy during daytime?
Yes No

3. *O*bserved
Has anyone *o*bserved you stop breathing during your sleep?
Yes No

4. Blood *p*ressure
Do you have or are you being treated for high blood *p*ressure?
Yes No

5. *B*MI
*B*MI more than 35 kg/m2?
Yes No

6. *A*ge
*A*ge over 50 yr old?
Yes No

7. *N*eck circumference
*N*eck circumference greater than 40 cm?
Yes No

8. *G*ender
*G*ender male?
Yes No

* Neck circumference is measured by staff
High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
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