



CompleteSleep  
MANAGEMENT INC.

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### ***Patient Sleep Questionnaire***

***Patient Name:*** \_\_\_\_\_ ***Sex:*** \_\_\_\_\_ ***Age:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

***Occupation:*** \_\_\_\_\_ ***Usual Work Hours/Days:*** \_\_\_\_\_

***Referring Physician:*** \_\_\_\_\_ ***Family Physician (PCP):*** \_\_\_\_\_

***Patient's email address:*** \_\_\_\_\_

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

***My Main Sleep Complaint(s) Is:***

\_\_\_\_\_ *trouble sleeping at night*                      *For how many months/years?* \_\_\_\_\_

\_\_\_\_\_ *being sleepy all day*                      *For how many months/years?* \_\_\_\_\_

\_\_\_\_\_ *snoring*                      *For how many months/years?* \_\_\_\_\_

\_\_\_\_\_ *unwanted behaviors during sleep, explain* \_\_\_\_\_

\_\_\_\_\_ *Other, explain* \_\_\_\_\_

***Sleep Pattern***

***Work Days (Weekday)***

***Off Days (Weekends)***

*Typical bedtime:* \_\_\_\_\_

*Typical amount of time it takes to fall asleep:* \_\_\_\_\_

*Typical number of awakenings per night:* \_\_\_\_\_

*List any activities that you normally do during nighttime awakening(s) (i.e. restroom, eat, watch TV):* \_\_\_\_\_

*Typical amount of time to fall back asleep after an awakening:* \_\_\_\_\_

*Typical wake up time:* \_\_\_\_\_

*Desired wake up time:* \_\_\_\_\_

**How do you usually awaken?**

**(i.e. alarm clock):** \_\_\_\_\_

**Typical time you get out of bed:** \_\_\_\_\_

**Total amount of sleep per night:** \_\_\_\_\_

**Number of naps per day:** \_\_\_\_\_

**Please check all of the following statements that are true about your sleep:**

**Sleep Habits**

- \_\_\_\_\_ I usually watch TV or read in bed prior to sleep
- \_\_\_\_\_ I frequently travel across 2 or more time zones
- \_\_\_\_\_ I drink alcohol prior to bedtime
- \_\_\_\_\_ I smoke prior to bedtime or when I awaken during the night
- \_\_\_\_\_ I eat a snack at bedtime
- \_\_\_\_\_ I eat if I awaken during the night
- \_\_\_\_\_ I typically awaken to urinate during sleep
- \_\_\_\_\_ I have trouble falling asleep
- \_\_\_\_\_ I awaken frequently during the night
- \_\_\_\_\_ I am unable to return to sleep easily if I awaken during the night
- \_\_\_\_\_ Thoughts start racing through my mind when I try to fall asleep
- \_\_\_\_\_ I awaken early in the morning, still tired but unable to return to sleep
- \_\_\_\_\_ I have nightmares as an adult
- \_\_\_\_\_ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- \_\_\_\_\_ I sweat a great deal during sleep
- \_\_\_\_\_ I cannot sleep on my back

**Breathing**

- \_\_\_\_\_ I have been told that I stop breathing while asleep
- \_\_\_\_\_ I awaken at night choking, smothering or gasping for air
- \_\_\_\_\_ I have been told that I snore
- \_\_\_\_\_ I have been told that I snore only when sleeping on my back
- \_\_\_\_\_ I have been awakened by my own snoring

**Restlessness**

- \_\_\_\_\_ I am a restless sleeper
- \_\_\_\_\_ I kick or jerk my legs and/or arms during sleep
- \_\_\_\_\_ I experience restlessness, tingling or crawling in my arms or legs
- \_\_\_\_\_ I experience an inability to keep my legs still prior to falling asleep
- \_\_\_\_\_ I talk in my sleep as an adult
- \_\_\_\_\_ I have sleep walked as an adult
- \_\_\_\_\_ I grind my teeth in my sleep

**Daytime Sleepiness**

- \_\_\_\_\_ I take daytime naps
- \_\_\_\_\_ I have a tendency to fall asleep during the day
- \_\_\_\_\_ I have experienced lapses in time or blackouts
- \_\_\_\_\_ I have fallen asleep while driving
- \_\_\_\_\_ I have had auto accidents as a result of falling asleep while driving
- \_\_\_\_\_ I fall asleep while watching TV

- \_\_\_\_\_ I fall asleep during conversations
- \_\_\_\_\_ I fall asleep in sedentary situations
- \_\_\_\_\_ I performed poorly in school because of sleepiness
- \_\_\_\_\_ I have had injuries as the result of sleepiness
- \_\_\_\_\_ I have experience sudden muscle weakness in response to emotions such as laughter, anger or surprise
- \_\_\_\_\_ I have experience an inability to move while falling asleep or when waking up
- \_\_\_\_\_ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up
- \_\_\_\_\_ I drink caffeinated beverages during the day \_\_\_\_\_ cups/bottles/cans per day

**Habits**

Do you smoke?  Yes  No

If Yes: What? Amount Per Day For How Many Years

Cigarettes \_\_\_\_\_ pack(s) \_\_\_\_\_ years

Cigars \_\_\_\_\_ cigars \_\_\_\_\_ years

Tobacco \_\_\_\_\_ pipes \_\_\_\_\_ years

Do you drink alcohol?  Yes  No

If Yes: What? Frequency Amount Per Week

Beer  Daily  Weekends  Rare \_\_\_\_\_ cans/week

Wine  Daily  Weekends  Rare \_\_\_\_\_ glasses/week

Liquor  Daily  Weekends  Rare \_\_\_\_\_ shots/week

**Social History**

Marital Status:  Single  Married  Separated  Divorced  Widowed

- \_\_\_\_\_ sleep alone
- \_\_\_\_\_ share a bed with someone
- \_\_\_\_\_ share a bedroom, but have separate beds
- \_\_\_\_\_ share a dwelling, but have separate bedrooms

Employment Status:  Employed  Unemployed  Retired

- \_\_\_\_\_ my job requires driving a vehicle
- \_\_\_\_\_ I work with dangerous equipment or substances
- \_\_\_\_\_ I am a shift worker on rotating shifts
- \_\_\_\_\_ I am a permanent or long term third shift worker
- \_\_\_\_\_ I am currently a student

**Medical History**

Vital Statistics:

What is your: Height? \_\_\_\_\_ Weight? \_\_\_\_\_ Neck Size: \_\_\_\_\_

What was your weight one year ago? \_\_\_\_\_ Five years ago? \_\_\_\_\_

**Past Sleep Evaluation and Treatment:**

- \_\_\_\_\_ I have had a previous sleep disorder evaluation
- \_\_\_\_\_ I have had previous overnight sleep studies
- \_\_\_\_\_ I have had daytime nap studies
- \_\_\_\_\_ I have been prescribed a CPAP or bi-level machine for home use
- \_\_\_\_\_ I have had surgical treatment for a sleep disorder
- \_\_\_\_\_ I have previously been prescribed medication for a sleep disorder
- \_\_\_\_\_ I have been previously treated for a sleep disorder

Please list the name of any pill that you have taken in the past for sleeping or for helping you stay awake:

Name

Did it help?

\_\_\_\_\_

Yes     No

\_\_\_\_\_

Yes     No

**Past Medical History:**

\_\_\_\_\_ Hypertension (high blood Pressure)

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Stomach or colon problems

\_\_\_\_\_ Lung problems/COPD/asthma

\_\_\_\_\_ Reflux

\_\_\_\_\_ Fibromyalgia

\_\_\_\_\_ Stroke

\_\_\_\_\_ TIA "Light Stroke"

\_\_\_\_\_ Blackouts

\_\_\_\_\_ Seizures

\_\_\_\_\_ Back or joint problems (arthritis)

\_\_\_\_\_ Cancer

\_\_\_\_\_ Thyroid problems

\_\_\_\_\_ Hepatitis/jaundice

\_\_\_\_\_ Hearing impairment

\_\_\_\_\_ Depression or severe anxiety

\_\_\_\_\_ Alcoholism

\_\_\_\_\_ Chemical dependency or abuse

**Female:**

\_\_\_\_\_ Premenstrual Syndrome

\_\_\_\_\_ Menopause

**Male:**

\_\_\_\_\_ Prostate problems

\_\_\_\_\_ Erectile dysfunction/impotence

**List other past medical problems and dates:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List Surgeries and the year**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the PAST 12 MONTHS check any of the following symptoms you have had?

**Yes No**

Frequent headaches

Fainting or passing out

Sudden loss of vision or strength, or inability to speak

Hearing loss or ringing in ear(s)

Hoarseness for more than 2-4 weeks

Nosebleeds

Cough for more than 2-4 weeks

**Yes No**

Frequent heartburn or indigestion

Abdominal pain

Frequent constipation

Frequent diarrhea

Rectal bleeding / black stools

Difficulty urinating/ incontinence

Blood in urine

**Yes No**

- Coughing up blood*
- Shortness of breath or wheezing*
- Swelling in feet or ankles*
- Chest pain, chest pressure or heaviness*
- Irregular heartbeat or sudden fast heartbeat*
- Difficulty swallowing or food "sticking"*

**Yes No**

- Urinating more than 2x per night*
- Pain in joints or bones*
- Unusual bruising or bleeding*
- Convulsions*
- Change in wart, mole or skin growth*
- Weight loss of more than 5-10 lbs.*

***Family History:***

*Has an immediate blood relative had any of the following?*

<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Relation</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Relation</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Cancer</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Stroke</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Diabetes</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Anxiety/Depression</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Hypertension</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Sleep Apnea</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Heart disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Narcolepsy</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Thyroid disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Other: _____</i>

**Epworth Sleepiness Scale:**

*How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:*

- 0 = *would never doze*
- 1 = *slight chance of dozing*
- 2 = *moderate chance of dozing*
- 3 = *high chance of dozing*

***Situation***

***Chance of Dozing***

<i>Sitting and reading</i>	_____
<i>Watching TV</i>	_____
<i>Sitting inactive in a public place (e.g. a theater or meeting)</i>	_____
<i>As a passenger in a car for an hour without a break</i>	_____
<i>Lying down to rest in the afternoon when circumstances permit</i>	_____
<i>Sitting and talking to someone</i>	_____
<i>Sitting quietly after a lunch without alcohol</i>	_____
<i>In a car, while stopped for a few minutes in the traffic</i>	_____
<b><i>Total:</i></b>	_____



<i>In the past 6 months, I have fallen asleep accidentally in some of these situations: eating a meal, talking on the phone, talking to someone, riding in a bus or car, watching TV, at a theater, reading a book, at a lecture</i>	1	2	3	4	5
<i>I got bad grades in school because I was too sleepy</i>	1	2	3	4	5
<i>I now have trouble doing my job because of sleepiness or fatigue</i>	1	2	3	4	5
<i>I often have to let someone else drive the car because I am too sleepy to do it</i>	1	2	3	4	5
<i>I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen</i>	1	2	3	4	5
<i>I am often unable to move (paralyzed) when I am waking up in the morning</i>	1	2	3	4	5
<i>Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it</i>	1	2	3	4	5
<i>I get "weak knees" when I laugh</i>	1	2	3	4	5
<i>I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion</i>	1	2	3	4	5
<i>I have high blood pressure (or once had it)</i>	1	2	3	4	5
<i>My desire or interest in sex is less than what it used to be</i>	1	2	3	4	5
<i>I am unhappy about loving relationships in my life</i>	1	2	3	4	5
<i>I have considered or attempted suicide</i>	1	2	3	4	5
<i>Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"</i>	1	2	3	4	5
<i>I smoke tobacco within two hours before bedtime</i>	1	2	3	4	5
<i>I have problems with my nose blocking up when I am trying to sleep (allergies, infections)</i>	1	2	3	4	5
<i>My snoring or my breathing problem is much worse if I sleep on my back</i>	1	2	3	4	5
<i>My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol</i>	1	2	3	4	5



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## *Bed Partner Questionnaire*

*Name of Patient:* \_\_\_\_\_ *Today's Date:* \_\_\_\_\_

*Check any of the following behaviors that you have observed the patient doing while asleep.*

- \_\_\_\_\_ *loud snoring*
- \_\_\_\_\_ *light snoring*
- \_\_\_\_\_ *twitching of legs or feet during sleep*
- \_\_\_\_\_ *pause in breathing*
- \_\_\_\_\_ *grinding teeth*
- \_\_\_\_\_ *sleep talking*
- \_\_\_\_\_ *sleepwalking*
- \_\_\_\_\_ *bed wetting*
- \_\_\_\_\_ *sitting up in bed but not awake*
- \_\_\_\_\_ *head rocking or banging*
- \_\_\_\_\_ *kicking with legs during sleep*
- \_\_\_\_\_ *getting out of bed but not awake*
- \_\_\_\_\_ *biting tongue*
- \_\_\_\_\_ *becoming very rigid and/or shaking*

*How long have you been aware of the sleep behavior(s) that you checked above?*

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*Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.*

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*If you have heard loud snoring, do you remember pauses in the snoring or occasional loud "snorts"?*

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