Comprehensive Sleep Medicine Associates
CSMA
888-503-2762
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| HOUSTON MEDICAL CENTER | SUGAR LAND | THE WOODLANDS AND CONROE | AUSTIN |
|---|---|---|---|
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BUSINESS OFFICE: 15423 CREEK BEND DRIVE, SUGAR LAND TX 77478

**Name:** _____ **Age:** ____ **Ht:** ___ft __ in **Wt:** _____ lbs Gender **(M) (F)**
Phone Number(s) Hm _____ Wk _____ Cell _____ Birth Date _____

1) Have you ever had a sleep evaluation before? Yes No If yes, are you currently using a treatment device regularly? Yes No
If yes then what type of device?_____ Your responses below should be in the context of how you function while using your device.
2) What time do you typically go into bed? _____ When do you typically wake-up to start your day? _____
3) Do you have difficulty falling asleep ? Yes No If yes, about how long does it take to fall asleep? back asleep? _____
If Yes, do you plan your next day while lying in bed trying to fall asleep? ..... Yes No
If Yes, do you have racing thoughts going through your mind while trying to fall asleep?..... Yes No
4) Do you have difficulty staying asleep ? Yes No How many awakenings per night? ____ Avg. time to return to sleep? _____
5) Do you take medications to fall or stay asleep? ..... Yes No
If yes, name and dose _____
6) Do you feel un-refreshed when you awaken to start your day? (non-restorative sleep) ..... Yes No
7) Do you experience an unsettled, restless sensation in your legs while lying in bed while awake? ..... Yes No
If yes, how often? ____Rarely (25%) ____Half the time (50%) ____Most of the time (75% or more)
If yes, does movement of your legs calm down the restless sensations at least briefly? ..... Yes No
8) Do you have, or have you been told that you kick or twitch your legs while you are asleep? ..... Yes No
9) Do you snore at night? ..... Yes No
If yes, how would you rate the severity? Mild Moderate Severe
10) Have others told you that you have pauses in breathing or gasping sounds while sleeping? ..... Yes No
If yes, how frequent are the pauses or gasping? __Throughout the night __Frequently __Occasionally
11) Does your bed partner frequently sleep in another room because of how you sleep? ..... (No bed Partner) ....or ..... Yes No
12) Check those that apply to you:
Do you frequently wake up with: __a dry mouth __headaches __excessive sweating __heart burn __chest pain
__ clenching jaws (or grinding teeth) in sleep __ aching in jaws or TMJ pain
__ choking or gasping __drooling on the pillow __ bed wetting (loss of bladder control)
__nasal congestion on awakening (which was not present when you went to bed)

13) Do you have unusual behaviors in your sleep? ..... Yes No
If yes, how often? _____ When did this start to occur? _____
If yes, briefly describe what you do in your sleep: _____
If yes, what part of the night do these typically occur? Within the first 90 minutes, first 3 hrs last 3 hrs of sleep?
14) Do you have difficulty maintaining concentration during the day? ..... Yes No
15) Are you sleepy during the day? ..... Yes No
16) Do you take naps often? ..... Yes No
If yes, for how long? _____ Do you usually dream during these naps? ..... Yes No
17) Daily consumption of: Caffeinated beverages? ____ Alcoholic drinks? ____ Tobacco Products? ____
18) Do you occasionally awaken feeling paralyzed? ..... Yes No
19) Do you experience sudden loss of strength in your legs or arms during the day? ..... Yes No
If yes, is it brought on by a sudden frightening event or laughter? ..... Yes No

Rank how likely it would be for you to become drowsy (like you're going to fall asleep) during the day in the following situations -- in contrast to just feeling tired in the following situations?
0 = never become drowsy 1 = Rarely become drowsy 2 = frequently become drowsy 3 = always become drowsy

| CHANCE OF BECOMING DROWSY | | | | SITUATIONS |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Sitting and reading |
| 0 | 1 | 2 | 3 | Watching TV |
| 0 | 1 | 2 | 3 | Sitting, inactive in a public place (e.g. theater) |
| 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 afternoon 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 for a few minutes in the traffic |

_____USE A SEPARATE SHEET OF PAPER IF NEEDED TO ANSWER THE QUESTIONS BELOW (NOT THE BACK OF THIS PAGE) _____

My sleep problems are:

My other medical problems are:

My medications are:

Have you had a sleep study before? Yes No

If so then When and Where? _____ Can you get report? Yes No

Have you had surgery for sleep apnea before? Yes No

Do you have COPD? Yes No Use Oxygen at night? Yes No ___L/min

Who filled out this questionnaire? _____

Referring Physician: _____

Physician's Office # _____

Physician's Fax# _____

Insurance: _____