Sleep Study Questionnaire

Braebon home sleep study

Name		Age	Height ft. in.
Date of Birth	Weight lbs.		
Phone	Do you smoke Yes No		Quit in (year)
Referring Dr.		Gender Male Female	
Do you feel you have Obstructed Sleep Apnea? Yes No		BMI	Neck size inches
City of Residence			State

Instructions: Use the scale below to choose the most appropriate number for each situation. Total the numbers.

0=would **NEVER** doze **1=SLIGHT** chance of dozing **2=MODERATE** chance of dozing **3=HIGH** chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car for an hour	
Laying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
In a car and stopped for a few minutes	
Total	

Please choose (X) the correct response to each question:

1. Do you snore?
   ☐ Yes ☐ No

2. If you snore: your snoring is?
   ☐ Slightly louder than breathing
   ☐ As loud as talking
   ☐ Louder than talking
   ☐ Louder than talking -Can be heard in adjacent rooms

3. How often do you snore?
   ☐ Nearly everyday
   ☐ 3-4 times a week
   ☐ 1-2 times a week
   ☐ 1-2 times a month
   ☐ Never or nearly never

4. Has your snoring bothered other people?
   ☐ Yes ☐ No

5. Has anyone noticed that you quit breathing in your sleep?
   ☐ Yes ☐ No

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Please choose (X) the correct response to each question:

Category 2

6. How often do you feel fatigued or tired after you sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

7. During your waking time, do you feel tired, fatigued or Not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

8. Have you ever fallen asleep or nodded off while driving?
   - ☐ Yes
   - ☐ No

9. If yes, How often does this occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

Category 3

10. Do you have High Blood Pressure?
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

Sleep Symptoms – Please choose (X) ALL that apply:

- ☐ Frequent bathroom visits nightly
- ☐ Gasping, choking, snorting during sleep
- ☐ Restless legs
- ☐ Limbs jerking / twitching at night
- ☐ Morning headaches
- ☐ Insomnia
- ☐ Restless sleep
- ☐ Memory loss
- ☐ Teeth grinding / clenching
- ☐ Waking up paralysed
- ☐ Audible or visual hallucinations around sleep
- ☐ Family history of sleep apnea

Health Issues – Please choose (X) ALL that apply:

- ☐ Heart Disease
- ☐ Stroke
- ☐ COPD
- ☐ Other lung issues
- ☐ Gastric Acid Reflux
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Previous Nasal Surgery
- ☐ Other_____
- ☐ Oxygen use
- ☐ Pacemaker
- ☐ Depression
- ☐ Erectile Dysfunction
- ☐

Alcohol Use:

- ☐ Daily
- ☐ 3-5 times week
- ☐ Weekly
- ☐ Weekend
- ☐ Special Occasion

Previous Sleep Diagnosis & Treatment

- ☐ Overnight Oximetry
- ☐ Medibyte / Type 3 Test
- ☐ Sleep Study in Lab
- ☐ CPAP / Bilevel therapy
- ☐ Dental Splint for Snoring or OSA

Medications: Names only

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_____

_____

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_____

I hereby attest all answers are truthful:

_____

Signature Date