
# Sleep Medicine Questionnaire – New Patient

**NAME: _____**
**DATE: _____**

Do you keep a regular sleep/wake schedule: ____

Weeknights:
Bedtime: ____ PM
Wake time: ____ AM.

Weekends:
Bedtime: ____ PM.
Wake time: ____ AM.

How long does it take you to fall asleep: _____

What is your preferred sleeping position: _____ (back/side).

After falling asleep, how many time(s) per night do you wake up: ____

Do you snore: ____

Do you stop breathing during sleep: ____

Do you wake up from sleep gasping for air or choking: ____

Do you feel refreshed upon waking up: ____

Do you wake up with a dry mouth in the morning: _____

During sleep do you usually breathe through your mouth or nose: ____.

Recent change in weight: _____.

Do you feel sleepy during the day: _____; If yes for how long have you felt sleepy during the day _____
Do you take daytime naps: _____. If yes, how many times/ week _____, How long does your nap last for? _____ mins. Are these daytime naps refreshing: _____.

Do you feel drowsy while driving: _____. Have you ever fallen asleep while driving: _____. Have you ever had a motor vehicle accident due to sleep related issues: _____.

Do you drink caffeinated beverages: _____. If yes: What do you drink ____; how much _____.

Have you had any nasal fracture or other facial trauma: _____

Have you had any upper airway surgery (i.e. – tonsillectomy, adenoidectomy, tracheostomy etc.): _____.

Do you have any reflux or heart burn during night: _____

Do you have any difficulty with memory or concentration: _____

Have you had any prior sleep study: _____

Past treatments for any sleep disorders: _____

Baylor Scott & White
PULMONARY AND CRITICAL CARE SPECIALISTS
DALLAS
*A member of HealthTexas Provider Network*

Name: _____ Date: _____

# EPWORTH SLEEPINESS SCALE

| Situation | Responses | Score |
|---|---|---|
| Sitting and reading | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| Watching TV | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| Sitting inactive in a public place, for example, a theater or a meeting | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| As a passenger in a car for an hour without a break | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| Lying down to rest in the afternoon when circumstances permit | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| Sitting and talking to someone | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| Sitting quietly after a lunch with no alcohol | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing 3 = high chance of dozing | |
| In a car, while stopped for a few minutes in traffic | 0 = would never doze<br>1 = slight chance of dozing | |

| | | |
|---|---|---|
| | 2 = moderate chance of dozing 3 = high chance of dozing | |
| **TOTAL SCORE** | | |


Name: _____ Date: _____

# STOP BANG Sleep Apnea Questionnaire

| **STOP** | | |
|---|---|---|
| Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)? | Yes | No |
| Do you often feel **T**ired, fatigued, or sleepy during daytime? | Yes | No |
| Has anyone **O**bserved you stop breathing during your sleep? | Yes | No |
| Do you have or are you being treated for high blood **P**ressure? | Yes | No |

| **BANG** | | |
|---|---|---|
| **B**MI more than 35 kg/m2 | Yes | No |
| **A**GE over 50 years old? | Yes | No |
| **N**ECK circumference > 16 inches (40 cm)? | Yes | No |
| **G**ENDER: Male? | Yes | No |

| **TOTAL SCORE** | | |
|---|---|---|