Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____
MED. REC. # _____
DOB _____
Patient Identification

SLEEP DISORDERS CLINIC:
PATIENT QUESTIONNAIRE

In order to better care for you, the BIDMC Sleep Disorders Clinic has put together this brief questionnaire for you to fill out before you see your provider today. Please answer the questions as best as you can.

I. REASON FOR VISIT / UPDATES FROM LAST VISIT:

_____

_____

II. FAMILY: Have any of your relatives (parents, brothers, sisters, children) been told they have/had:
☐ No change since last visit

	No	Yes	Which Relative?
Snoring or sleep apnea			
Obesity			
Heart problems			
Insomnia/trouble sleeping			
Depression			
Other Mood Disorder			

III. REVIEW OF SYSTEMS:

	No	Yes	*If Yes*, please provide details
Has your weight changed over the past 5 years? Since your last visit?	☐	☐	
Do you have much nasal congestion?	☐	☐	
Do you have seasonal allergies?	☐	☐	
Do you get many headaches?	☐	☐	
Do you have numbness or tingling in your leg(s)?	☐	☐	
Do you have a history of claustrophobia?	☐	☐	
Do you feel depressed or sad most of the time?	☐	☐	
Do you have a lot of anxiety or worry excessively?	☐	☐	
Do you have trouble with concentration or memory?	☐	☐	
Do you get short of breath when working hard or exercising?	☐	☐	
Do you get short of breath when you are resting?	☐	☐	
Do you use oxygen at home?	☐	☐	
Do you have chest pain?	☐	☐	
Do you get up in the middle of the night to go to the bathroom?	☐	☐	
Do you have chronic pain?	☐	☐	If Yes, where?
Do you have reflux or heart burn that bothers you at night?	☐	☐	

IV. SLEEPINESS SCALE: On an average day, **what are your chances of dozing** while doing any of the following things? (If you do not usually do the activitiy listed, please give your best estimate):

	Would never doze (0)	Slight chance of dozing (1)	Moderate chance of dozing (2)	High chance of dozing (3)
1. Sitting and reading	☐	☐	☐	☐
2. Watching television	☐	☐	☐	☐
3. Sitting still in a public place	☐	☐	☐	☐
4. Car passenger for one hour	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car, stopped for a few minutes in traffic	☐	☐	☐	☐
	Epworth Sleepiness Total Score: ____/ 24			

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SLEEP DISORDERS CLINIC:
PATIENT QUESTIONNAIRE

II. SLEEP QUESTIONNAIRE: Please mark one box per row. Answer as best as you can.

In the past 7 days……..	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
1. My sleep was restless	☐ (1)	☐ 2)	☐ (3)	☐ (4)	☐ (5)
2. I was satisfied with my sleep	☐ (5)	☐ (4)	☐ (3)	☐ (2)	☐ (1)
3. My sleep was refreshing	☐ (5)	☐ (4)	☐ (3)	☐ (2)	☐ (1)
4. I had difficulty falling asleep	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)
In the past 7 days……..	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5. I had trouble staying asleep	☐ (1)	☐ 2)	☐ (3)	☐ (4)	☐ (5)
6. I had trouble sleeping	☐ (1)	☐ 2)	☐ (3)	☐ (4)	☐ (5)
7. I got enough sleep	☐ (5)	☐ (4)	☐ (3)	☐ (2)	☐ (1)
In the past 7 days……..	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
8. My sleep quality was	☐ (5)	☐ (4)	☐ (3)	☐ (2)	☐ (1)

Sleep Disturbance Total Score: _____/ 40

In the past 7 days……..	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
1. I had a hard time getting things done because I was sleepy	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)
2. I felt alert when I woke up	☐ (5)	☐ (4)	☐ (3)	☐ (2)	☐ (1)
3. I felt tired	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)
4. I had problems during the day because of poor sleep	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)
5. I had a hard time concentrating because of poor sleep	☐ (1)	☐ 2)	☐ (3)	☐ (4)	☐ (5)
6. I felt irritable because of poor sleep	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)
7. I was sleepy during the daytime	☐ (1)	☐ 2)	☐ (3)	☐ (4)	☐ (5)
8. I had trouble staying awake during the day	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)

Sleep Impairment Total Score: _____/ 40

Do not Scan into OMR. Worksheet Only