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**HOUSTON
MEDICAL CENTER**

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AUSTIN

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F: (512) 691-7080

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: _____