The Sleep Center
UINTAH BASIN HEALTHCARE

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Welcome to Uintah Basin Healthcare's Sleep Center. We look forward to working with you to help meet your sleep needs!

We highly value your appointment with our sleep specialist. To ensure the most efficient use of your time, please complete the attached questionnaire prior to your arrival. Please bring the questionnaire with you as the provider will review this information with you.

Please remember to bring the following to your visit:

1. **Completed Patient Questionnaire**
   Please list all medications including over-the-counter medications and herbal products.
2. **Medical Records or Previous Testing Results**
   - Previous Sleep Studies including any home sleep study
     - Please include actual graphs
   - Overnight Pulse Oximeter Report (home recording of your oxygen levels)
3. **Your Bed Partner**
   Many sleep related issues are often observed by your bed partner. If your bed partner is unavailable to attend the appointment, please have them list on a sheet of paper any specific items they observe about your sleep. Although your bed partner can provide us with valuable information during your daytime clinic visit, he or she will not be asked to join you if a night study is scheduled. There are no facilities available in the sleep center for family members, unless the physician determines that special arrangements should be made.

4. **The Name of Your Referring/Primary Care Physician**
   If you would like a copy of your evaluation and test results sent to your physician, please come prepared with his/her full name, address, and telephone number. You will also be required to sign a release of records upon your arrival.

Thank you for choosing Uintah Basin Healthcare!
We look forward to seeing you!

Date: _____ / _____ / _____

Name: _____, _____, _____
Last First MI

DOB _____ Age _____ Current Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Ethnicity: ☐White ☐Hispanic ☐Asian ☐African American ☐Pacific Islander
☐Other _____

What is your primary Language? _____

Physician Information

Who is your Primary Care Physician? _____

Name of Physician/Health Care Provider who referred you to the Sleep Center?

_____

Are there other Physicians/Health Care providers who referred you to the Sleep Center?

_____

Have you ever had: (please check any that apply)

Previous evaluation for your sleep disturbance? ☐NO ☐YES, from whom

A measurement of your nighttime oxygen levels? (overnight oximetry)
☐NO ☐YES: ☐Normal ☐Abnormal ☐Don't know

A sleep study performed in the Sleep Center?
☐NO ☐YES: ☐Normal ☐Abnormal ☐Don't know

I am currently using: ☐ CPAP ☐ Bilevel ☐Don't know

Please check all that apply

1. The main reason I am here is:
☐I think I have a sleep problem
☐My bed partner or someone who saw me sleeping thinks I have a sleep problem
☐My doctor or another health care provider thinks I have a sleep problem
☐Wake up feeling non-refreshed/I feel sleep throughout the day
☐Snoring
☐I need a sleep evaluation to maintain/reinstate a professional license
☐I am not sure why I am here

2. The most worrisome concern I have about my sleep problem is:
☐My sleep problem is impacting my quality of life (for example: I am often very tired)
☐My sleep problem may be causing or contributing to another medical problem
☐I am worried my sleep problem may damage my health
☐I am worried about my safety, or the safety of others
☐My sleep problem causes someone else to not sleep well
☐I am concerned that my sleep problem may impact my professional license
☐I do not really have any specific concerns, but it was recommended I make this appointment

3. The most important thing I need from the clinic visit is:
☐To determine if I have a sleep problem
☐To treat the sleep problem I have
☐To feel better
☐To satisfy the person who referred me
☐Clearance for professional activities
☐Unsure

4. The worst symptom I have related to my sleep problem is:
☐Tiredness
☐Fatigue
☐Can't go to sleep when I want to
☐Can't stay asleep
☐Snoring or irregular breathing that bothers someone else
☐Movements or behaviors that bother someone else
☐I don't have any of these things

TYPICAL **WEEKDAY** SLEEP SCHEDULE

I first get into bed at approximately_____. ☐AM☐ PM
I turn out the lights at approximately_____. ☐AM☐ PM
It takes approximately_____ minutes to fall asleep.
I wake up approximately _____ times per night.
I have difficulty getting back to sleep: ☐ Usually☐ Rarely
My final awakening is approximately: _____. to _____. ☐AM☐ PM
After my final awakening, I usually get out of bed: ☐Immediately ☐After 30 minutes or more

TYPICAL **WEEKEND** SLEEP SCHEDULE

I first get into bed at approximately_____. ☐AM☐ PM
I turn out the lights at approximately_____. ☐AM☐ PM
It takes approximately_____ minutes to fall asleep.
I wake up approximately _____ times per night.
I have difficulty getting back to sleep: ☐ Usually☐ Rarely
My final awakening is approximately: _____ to _____ ☐AM☐ PM
After my final awakening, I usually get out of bed: ☐Immediately ☐After 30 minutes or more

Please check all that apply

☐I have snoring that bothers people
☐I only snore when I am lying flat on my back
☐I have been told that I stop breathing in my sleep
☐I have awakened feeling short of breath or choking
☐I try to stay alert during the day, but often fall asleep, even if I've had a full night's sleep
☐Sleepiness is a problem during work or at school
☐I feel drowsy when driving, even if I've had a full night's sleep
☐At night, I am usually quite concerned about whether I will be able to **fall** asleep
☐At night, I am usually quite concerned about whether I will be able to **stay** asleep
☐I have relied on sleep pills/aids
☐I do not look forward to bedtime because I always have trouble sleeping
☐Thought flood my mind and prevent me from sleeping.
☐I frequently wake up in the middle of the night and can't go back to sleep

Please check all that apply

☐I wake up too early in the morning
☐I worry and have trouble relaxing
☐I lie awake for at least 30 minutes or more before I can fall asleep
☐I read in bed
☐I have a strong tendency to go to bed late and wake up late
☐I have a strong tendency to go to bed early and wake early
☐My sleep pattern is quite variable
☐I have a shift work schedule
☐I feel I get enough sleep: ☐ often ☐sometimes☐ rarely
☐I sleep walk
☐I sleep talk
☐I have very scary dreams/nightmares
☐I eat in my sleep
☐I grind my teeth
☐My legs bother me at night
☐I have "Charlie Horses"/muscle cramps in my legs at night
☐Although I can sleep through the night or during the day, I feel muscle tension, crawling sensations, or my legs ache
☐My legs bother me at night and feel better when I move them
☐Strange things happen to me as I am falling asleep
☐I have a weakness and or loss of strength if I experience a sudden, strong emotion
☐While falling asleep or shortly afterwards, I experience vivid, dreamlike scenes
☐I often feel paralyzed for brief periods while falling asleep or just after waking up

My Current Medications: _____

_____

_____

Please check all that apply

☐Asthma
☐COPD
☐Pulmonary Hypertension
☐Airway Abnormality
☐Hayfever/Allergies
☐Gastroesophageal Reflux
☐Peptic Ulcer
☐Liver Disease
☐Diabetes
☐Thyroid Disease
☐Adrenal Disease
☐Seizures
☐Parkinson's
☐Alzheimer's
☐Hypertension
☐Coronary Disease/Heart Attack
☐Heart Failure
☐Atrial Fibrillation/ Irregular Heart Rate
☐Chronic Fatigue/Fibromyalgia
☐Developmental Delay
☐Depression
☐Bipolar Disorder/Schizophrenia
☐Chemical Dependency
☐Dentures
☐Persistent Cough
☐Wheezing/Coughing
☐Dyspnea/Shortness of Breath
☐Post Nasal Drip
☐Sinus Congestion
☐Trouble Swallowing/Hoarseness
☐Trouble Breathing Through Nose
☐Frequent Sore Throats
☐Heartburn
☐Frequent Use of Antacids
☐Weight Gain
☐Weight Loss
☐Headaches
☐Memory Loss
☐Chest Pain at Rest/During Exercise
☐High Blood Pressure
☐Swelling in Ankles
☐Feeling Sad, Down or Depressed
☐Feelings of Anxiety or Panic
☐Frequent Nighttime Urination
☐Impotence/Ineffectiveness
☐Losing Sexual Drive
☐Jaw/Face Pain
☐Night Sweats
☐Rash/Itch
☐Cancer

I have had surgery on, or for: ☐Vocal Cords ☐Nose ☐Palate ☐Airway☐ Sinuses ☐Jaw☐ Brain☐ Thyroid ☐Acid Reflux ☐Gastric Bypass/Banding
Please list any other surgeries not listed above _____.

Other Medical Problems/Hospitalizations: _____

_____

_____

I need assistance with: ☐walking ☐dressing ☐bathing/toileting

I am: ☐Single ☐Married ☐Divorced ☐Widowed

I live: ☐ Alone with ☐Spouse/Partner ☐Child/Children ☐Other:
_____.

I live in: ☐an apartment/condo ☐a house ☐an assisted living facility/group home

Highest level of education:☐ Grade School ☐High School/GED ☐Some College ☐Bachelor's Degree☐ Graduate Degree

Occupation: _____

☐I drink caffeinated beverages. How many drinks per day _____.

☐I drink alcohol. How many drinks per day _____.

☐I smoke or have smoked in the past. List number of pack per day _____ , for how many years? _____ I have quit smoking. How long ago did you quit?_____

☐I exercise regularly (at least 3 times/week for 30 minutes)

☐I use recreational drugs. Specify _____

In general, I am able to, or find it easy to follow through with treatments that are prescribed to me: ☐Highly Likely☐ Somewhat Likely ☐Not Very Likely ☐Not At All ☐ Unsure

I usually feel as though I'm a participant in my health care:
☐Strongly Agree☐ Agree☐ Disagree ☐Strongly Disagree ☐Unsure

I have a family history of:
☐Insomnia ☐Narcolepsy ☐Sleep Apnea☐ Restless Legs ☐Excessive sleepiness ☐Snoring

Epworth Scale

Under normal circumstances, how likely are you to doze off and/or fall asleep rather than just feel tired in the following situations? Even if you have not experienced some of these situations, try to imagine how they would affect you. Use the following scale to choose the most appropriate number for each situation.

(0) Would never doze or sleep
(1) Slight chance of dozing/sleeping
(2) Moderate chance of dozing/sleeping
(3) High chance of dozing/sleeping

DIRECTIONS: Please check the appropriate box for your answer to each question using the above rating scale. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

Activity	Score			
	0	1	2	3
Sitting and Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in public areas	☐	☐	☐	☐
Lying down in the afternoon	☐	☐	☐	☐
Sitting quietly after lunch (no alcohol)	☐	☐	☐	☐
Riding as a passenger in a motor vehicle for 1+ hours	☐	☐	☐	☐
Stopped for a few minutes in traffic when driving	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐

Epworth Total Score: _____/24

STOPBANG Questionnaire

Vitals: Height _____ **Weight:** _____ **Neck Size:** _____

Waist Circumference: _____

Answering "yes" to 3 or more questions indicates that you are at high risk for having Obstructive Sleep Apnea.

STOP-BANG Questions:

YES	NO	
☐	☐	**1. Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
☐	☐	**2. Tiredness/Fatigue:** Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?
☐	☐	**3. Observed Apnea:** Has anyone ever observed you stop breathing during your sleep?
☐	☐	**4. Pressure:** Do you have or are you being treated for high blood pressure at home?
☐	☐	**5. Body Mass Index:** Do you weigh more for your height than is shown in the tables to the right?
☐	☐	**6. Age:** Are you older than 50 years?
☐	☐	**7. Neck Size:** Does your neck measure more than 15 ¾" (40 cm) around? Measurement in cm ___
☐	☐	**8. Gender:** Are you male?

Height	Weight (lb)	Height	Weight (lb)
4'10"	167	5'8"	230
4'11"	173	5'9"	237
5'	179	5'10"	243
5'1"	185	5'11"	250
5'2"	191	6'	258
5'3"	197	6'1"	265
5'4"	204	6'2"	272
5'5"	210	6'3"	279
5'6"	216	6'4"	287
5'7"	223	6'5"	295

Number of "Yes" Answers _____

Weights shown in the tables above correspond to a BMI of 35 for a given height.

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

Some people have difficult performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off," or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put a (_) in the box for your answer to each question. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	(4) No Difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
General Productivity					
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?		☐	☐	☐	☐
2. Do you generally have difficulty remembering things, because you are sleepy or tired?		☐	☐	☐	☐
	Total Questions answered >0 ____/# questions answered=_____				
Activity Level					
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?	☐	☐	☐	☐	☐
	Total Questions answered >0 ____/# questions answered=_____				
Vigilance					
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐	☐	☐	☐	☐

7. Do you have difficulty watching a movie or videotape because you are sleepy or tired? ☐ ☐ ☐ ☐ ☐

8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired? ☐ ☐ ☐ ☐

	(0) I don't do this activity for other reasons	(4) No Difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
Social Outcomes					
9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?		☐	☐	☐	☐

Total Questions answered >0 ____/# questions answered= _____

Intimacy and Sexual Relationships

10. Has your desire for intimacy or sex been affected because you are sleepy or tired? ☐ ☐ ☐ ☐ ☐

Total Questions answered >0 ____/# questions answered= _____

Subscale: _____ + _____ + _____ + _____+ _____ / Total subscales answered= _____

Multiply Mean x 5 =_____

Thank you for completing this questionnaire.

Please only proceed with this questionnaire if the patient being seen is between the ages of 2 and 18 years of age. Provider will document these in the child's medical record.

BEARS SLEEP SCREENING ALGORITHM

The "BEARS" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

Examples of developmentally appropriate trigger questions:

	Toddler/preschool (2-5 years)	School-aged (6-12 years)	Adolescent (13-18 years)
1. Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
2. Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does she still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day or take haps? (P) Do you feel tired a lot? (C)	Do you feel sleep a lot during the day? In school? While driving? (C)
3. Awakenings during the night	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night? Any sleepwalking or nightmares? (P) Do you wake up a lot at night? Have trouble getting back to sleep? (C)	Do you wake up a lot at night? Have trouble getting back to sleep? (C)
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? What are they?	What time does your child go to bed and get up on school days? Weekends? Do you think he/she is getting enough sleep? (P)	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
5. Snoring	Does your child snore a lot or have difficulty breathing at night?	Does your child have loud or nightly snoring or any breathing difficulties at night? (P)	Does your teenager snore loudly or nightly? (P)

(P) Parent-directed question
(C) Child-directed question

Source: "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins