



Central Oregon

Sleep Disorders Center

147 Shevlin-Hixon Dr. Ste.104
Bend, OR. 97702
541-306-4882 541-306-4904

Your Consultation appointment with Dr. Irbe is ___/___/___ at ____.

You will be charged **\$25.00** if you do not give 24 hours notice for cancellation or fail to show.

If your insurance requires a referral from your primary physician, it is your responsibility to make sure that the referral is in place prior to your visit to the clinic.

INSTRUCTIONS FOR COMPLETING SLEEP DISORDERS CENTER QUESTIONNAIRE

1. QUESTIONS ABOUT YOUR SLEEP AND WAKE BEHAVIOR

Fill in your name, sex, phone number, etc. ***Please answer all of the questions.***
It is important to bring this form at the same time as your appointment.

2. OBSERVER QUESTIONNAIRE

As you are not aware of your behavior when you are asleep, we need information from someone watching you sleep to assess your sleep problem. This can be your spouse, relative, friend or someone who has observed you sleep. **It is important to bring this form at the same time as your appointment.**

3. TESTING PRE-REGISTRATION FORM

To register you for a sleep study, we need a completed pre-registration form along with your sleep questionnaire. Do not return it separately. ***Please answer all questions that apply.***
It is important to bring this form at the time of your appointment.

4. SLEEP LOG - BEGIN TONIGHT

The sleep log will provide us with important information about your sleep over a period of two weeks. Detach the log, keep it by your bedside and fill it out daily. Return it when completed or bring it to your appointment with the sleep doctor. **It is important to bring this form at the time of your appointment.**

5. **If you do not present your insurance card at the time of service, you will be responsible for the bill and you will need to bill your insurance yourself.**

Your cooperation will expedite your appointment and provide the information we need to appropriately diagnose and provide treatment.

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SLEEP DISORDERS QUESTIONNAIRE

Name: _____ Date: _____ Home Phone: _____
 Sex: _____ Age: _____ Birthdate: _____ Work Phone: _____
 Occupation: _____ Doctor: _____ Other Doctors: _____

- 1) Who originally motivated you to seek evaluation? _____
 2) Why did you (or your doctor) contact the Sleep Disorders Center? _____

3) **SLEEP SCHEDULE:**

- a. When is your usual bedtime (lights out)? _____ am/pm
 b. How long do you usually take you to fall asleep? _____ minutes
 c. How many hours of sleep do you get each night? _____ hours
 d. How many times do you usually awaken each night? _____ times
 e. How long is your average awakening? _____ minutes
 f. How many times do you get out of bed each night? _____ times
 g. When do you usually get out of bed in the morning? _____ am/pm
 h. Are you rested in the morning? _____ yes _____ no

4) **AT BEDTIME**, how often do you:

- | | many
/night | daily | few
/month | few
/year | never |
|--|----------------|-------|---------------|--------------|-------|
| a. take over 45 minutes to fall asleep? | [] | [] | [] | [] | [] |
| b. feel sad, depressed, anxious or tense? | [] | [] | [] | [] | [] |
| c. worry about not sleeping? | [] | [] | [] | [] | [] |
| d. worry about work or personal issues? | [] | [] | [] | [] | [] |
| e. have leg restlessness, aching or twitching? | [] | [] | [] | [] | [] |
| f. arouse from extremity jerks? | [] | [] | [] | [] | [] |
| g. have dreams when falling asleep? | [] | [] | [] | [] | [] |
| h. have delayed sleep due to pain? | [] | [] | [] | [] | [] |

5) **WHILE SLEEPING** how often do you:

- | | [] | [] | [] | [] | [] |
|---|----|----|----|----|----|
| a. awaken and fear you won't return to sleep? | [] | [] | [] | [] | [] |
| b. have restless, disturbed sleep? | [] | [] | [] | [] | [] |
| c. awaken due to pain? | [] | [] | [] | [] | [] |
| d. awaken due to snoring? | [] | [] | [] | [] | [] |
| e. awaken with a dry throat? | [] | [] | [] | [] | [] |
| f. awaken with gasping, choking, or difficulty breathing? | [] | [] | [] | [] | [] |
| g. awaken with chest pain or palpitations? | [] | [] | [] | [] | [] |
| h. awaken with heartburn or indigestion? | [] | [] | [] | [] | [] |
| i. talk in your sleep? | [] | [] | [] | [] | [] |
| j. walk in your sleep? | [] | [] | [] | [] | [] |
| k. wake up screaming, violent or confused? | [] | [] | [] | [] | [] |
| l. grind your teeth at night? | [] | [] | [] | [] | [] |
| m. awaken with leg jerks or body "jumps"? | [] | [] | [] | [] | [] |

n. have unusual or excessive movements while asleep?

6) My sleep is frequently disturbed by:

- | | | | |
|--------------------|--------------------|-------------------------|--------------------------|
| a. _____ heat/cold | b. _____ hunger | c. _____ nightmares | d. _____ cramps |
| e. _____ sweating | f. _____ headaches | h. _____ thirst | i. _____ indigestion |
| j. _____ noise | k. _____ gas | l. _____ pain | m. _____ need to urinate |
| n. _____ cough | o. _____ heartburn | p. _____ my bed partner | |

7) <u>How often do you:</u>	daily	few /month	few /year	never
a. depend on an alarm to wake up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. "sleep in" on days off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. have a very hard time waking up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. feel unable to move when waking up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. wake up confused or disoriented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. wake up with a headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. wake up nauseated (sick to your stomach)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. wake up with a dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. wake up 1 or 2 hours before you have to get up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. wake up feeling well rested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8) DAYTIME SLEEPINESS:

Is daytime sleepiness a problem for you? _____

Do you altered your daily schedule due to sleepiness? _____

Have you altered/lost/changed jobs due to sleepiness? _____

What activities are most likely to induce daytime sleepiness? _____

How often does poor memory or confusion bother you? _____

9) How often do you:	many /day	few /day	few /week	never
avoid or interrupt activities due to sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
'sleep in' on days off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to bed early because of sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
let yourself nod off in quiet situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do things to fight drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nod off despite efforts to stay alert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10 What is your chance of dozing during the following activities:

	high	moderate	slight	never
a. sitting & reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. sitting quietly in a theater or meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. as a passenger in a car for an hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. sitting & talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. in a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Daytime Sleepiness:

How many naps do you take in a usual week? _____ naps

How long are your naps? _____ hrs

Are the naps refreshing? _____ yes _____ no
How much does daytime fatigue or sleepiness bother you? _____

12. How often do you feel weakness when laughing, surprised, or angry? _____

13. Does anyone in your family have a sleep problem? Please describe it. _____

14. How much of the following do you take? During a typical day Within 4 hours of going to bed

coffee or tea (caffienated)	_____ cups	_____ cups
soda (caffienated)	_____ oz	_____ oz
beer/wine	_____ cups	_____ cups
other alcohol	_____ oz	_____ oz
tobacco	_____ packs	_____ cigarettes

15. Please list any sleeping pills or stimulants have taken. DID IT HELP?

_____	Yes	_____	No	_____
_____	Yes	_____	No	_____
_____	Yes	_____	No	_____

16. What medications are you allergic to? _____

17. List the name and dose of medications you have taken. (in the last 30 days)

18) Other current medical problems:

19) Past operations: _____

20) How many times each week do you participate in a sport or other exercise? _____ /week

21) What are your usual work hours? starts _____ ends _____

22) Does your work change shifts? yes _____ no _____

23) What is your current weight _____ height _____ in

24) How much has your weight changed in the last 6-12 months? _____ lb.

25) Have you had or used:

- | | | | | | |
|----------------------|-----|----------------------|-----|--------------------|-----|
| TMJ Syndrome | [] | Chronic pain | [] | Ear infections | [] |
| Sinus condition | [] | Dentures | [] | Ear perforation | [] |
| Sinus surgery | [] | Hayfever/allergies | [] | Orthodontic braces | [] |
| Dry eyes | [] | Broken nose | [] | Migraine | [] |
| Bite plate | [] | Melatonin | [] | Oximetry | [] |
| “Breathe Right” tape | [] | Laser throat surgery | [] | Tonsillectomy | [] |
| “Snore Ban” | [] | | | | |

**Central Oregon Sleep Disorders Center
OBSERVER QUESTIONNAIRE**

Name of patient: _____ Observer: _____

I have observed this person's sleep: never _____ once or twice _____ often _____ every night _____
Indicate how often you have observed the following behaviors in the person WHILE ASLEEP.

	Many /night	few /night	several /month	several /year	never
light snoring	[]	[]	[]	[]	[]
loud snoring	[]	[]	[]	[]	[]
occasional loud snorts	[]	[]	[]	[]	[]
choking, gasping	[]	[]	[]	[]	[]
pauses in breathing	[]	[]	[]	[]	[]
snoring disturbs others	[]	[]	[]	[]	[]
twitching or jerking of arms or legs	[]	[]	[]	[]	[]
grinding teeth.....	[]	[]	[]	[]	[]
sleep walking	[]	[]	[]	[]	[]
sleep talking	[]	[]	[]	[]	[]
bed wetting	[]	[]	[]	[]	[]
awakening with pain	[]	[]	[]	[]	[]
head rocking or banging	[]	[]	[]	[]	[]
biting tongue	[]	[]	[]	[]	[]
becoming very rigid and/or shaking.....	[]	[]	[]	[]	[]
sitting up/getting out of bed but not awake	[]	[]	[]	[]	[]
apparently sleeping even if he/she behaves otherwise.....	[]	[]	[]	[]	[]
other	[]	[]	[]	[]	[]

Please describe the length, frequency and effort of pauses in breathing: _____

Please describe unusual sleep behaviors in more detail. What do you see? How often? How long?
Early or late in the night? Related to position or other factors? _____

How sleepy is the subject during the day? never mild moderate severe

Has this person ever fallen asleep during normal activities or in dangerous situations? no [] yes []

if yes explain: _____

Does this person have any special problems/needs?

- Wheel chair assistance Walker
- Assistance in and out of bed. Hearing Aids Assistance with taking medications.
- Incontinence (bed wetting). Dementia Artificial Limbs
- Other: _____