SLEEP HISTORY QUESTIONNAIRE – ATTACHMENT A

Patient Name: _____ Date: _____

Please check the appropriate box or give shot answers for the following:

	YES	NO
1. Do you feel sleepy or have "sleep attacks" during the day?	☐	☐
2. Do you nap during the day?	☐	☐
3. Do you have trouble concentrating during the day?	☐	☐
4. Do you have trouble falling asleep when you first go to bed?	☐	☐
5. Do you awaken during the night?	☐	☐
6. Do you awaken more than once?	☐	☐
7. Do you awaken too early in the morning?	☐	☐

8. How long have you had trouble sleeping?

9. What do you think precipitated the problem?

_____

_____

10. How would you describe your usual night's sleep (hours of sleep, quality of sleep, etc.)?

11. Does your schedule for awaking from sleep on the weekend differ from what it is during the week?	☐	☐
12. Do others live at home who interrupt your sleep?	☐	☐
13. Are you regularly awakened at night by pain or the need to use the bathroom?	☐	☐
14. Does your job require shift changes or travel?	☐	☐
15. Do you drink caffeinated beverages (coffee, tea, or soft drinks)?	☐	☐

16. Apart from difficulty sleeping, what, if any, other medical problems do you have?

_____

_____

17. What sleep medications, prescription or non-prescription, do you take? (please include the dose, how often you take it, and for how many months/years you have taken it)

_____

_____

18. What other prescriptions and over-the-counter medications do you regularly use? (please include the dose, frequency, and duration)

_____

_____

19. Do you snore? ☐ ☐

20. My main sleep complaint is:
    □ Trouble sleeping at night
    □ Being sleepy all day
    □ Unwanted behaviors during sleep. Please Explain:
    _____
    _____

Usual sleep habits:

Bedtime _____ a.m./p.m. Number of awakenings _____

Wake time _____ a.m./p.m. Naps Per week _____

DIRECTIONS: Check any statement, which currently applies to you.

□ unrefreshing naps
□ restless sleeper
□ stop breathing during sleep
□ awaken with headaches
□ have high blood pressure
□ cough up sputum or mucus at night
□ falling asleep at inappropriate times
□ refreshing naps
□ vivid dreams
□ paralysis or inability to move on awakening
□ eat excessive amounts of sweets or chocolate
□ kicking or twitching during sleep
□ legs jerk during sleep
□ experience inability to keep legs still
□ trouble falling asleep
□ awaken long before it is necessary
□ sleep better in unfamiliar setting
□ awaken with choking sensation
□ sweat a lot during sleep
□ difficulty waking in the morning
□ have gained more than 10 lbs. in the last year
□ unable to sleep in a flat position
□ driving accidents/near accidents due to sleepiness
□ dream a lot
□ dreams or hallucinations while awake
□ sudden sensation of weakness in knees or legs
□ was hyperactive child or teenager
□ driven miles past destination with little awareness
□ experience restlessness, or tingling, crawling in legs
□ sleep with ear plugs or eyeshades
□ trouble returning to sleep
□ don't feel tired at bedtime
□ light sleeper
□ very loud snorer

EXCESSIVE DAYTIME SLEEPINESS (EPWORTH SLEEPING SCALE)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = Would never doze 1 = Slight chance of dozing

2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of dozing 0-3
➢ Sitting and reading	____
➢ Watching TV	____
➢ Sitting inactive in a public place (e.g. a theater or a meeting)	____
➢ As a passenger in a car for an hour without a break	____
➢ Lying down to rest in the afternoon when circumstances permit	____
➢ Sitting and talking to someone	____
➢ Sitting quietly after a lunch without alcohol	____
➢ In a car, while stopped for a few minute4s in the traffic	____
TOTAL	____

SPOUSE OR ROOMMATE QUESTIONNAIRE

Check any of the following behaviors that you have observed the patient doing while asleep.

□ loud snoring □ light snoring

□ twitching of legs or feet during sleep □ pause in breathing

□ grinding teeth □ sleep talking

□ sleep walking □ bed wetting

□ sitting up in bed but not awake □ head rocking or banging

□ kicking with legs during sleep □ getting out of bed but not awake

□ biting tongue □ becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

_____

Describe the sleep behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night

_____

_____

If you have hard, loud snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”?

_____

Sharp Community Medical Group
STATEMENT OF MEDICAL NECESSITY

HOME BASED SLEEP APNEA STUDY – ATTACHMENT B

_____ has been evaluated for _____

Height: Feet _____ Inches _____ | Weight_____ lbs. | Gender _____ | Race _____
Neck size _____ inches (measure neck at the widest part of the neck)

A sleep apnea study has been ordered and is medically necessary based upon the following clinical symptoms.

The patient history reveals the following conditions:

□ Excessive daytime somnolence
□ Snoring
□ Falling asleep while driving
□ Polycythemia
□ Wakens with sensation of choking and gasping
□ Wakens with headache
□ Heart Disease
□ Hypertension
□ Nocturia
□ Impotency
□ GE reflux
□ Pedal Edema
□ Depression
□ Other _____

The patients sleep observer gives the following description of sleep abnormalities:

□ Soft or loud snoring
□ Observed apnea during sleep

Medical examination has revealed:

□ Hypertension
□ Pedal Edema
□ Maxillomandibular alformation
□ Adenotonsillar enlargement

The above factors indicate the high probability of sleep apnea, upper airway resistance syndrome, or hypoventilation that should be treated if diagnostically confirmed through a sleep study.