Miami Shores Neurology & Sleep Institute, LLC
9999 NE 2nd Ave Suite 208
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www.msneurosleep.com
info@msneurosleep.com
PH: 305 754 6240 Fax: 305 754 6255

Name: ____________________ Date: ____________________

QUESTIONNAIRE

WORK SCHEDULE

When does your usual work shift start?	________am	________pm
When does your usual work shift end?	________am	________pm
Do you do shift work?	◯ Yes	◯ No

SLEEP SCHEDULE — WEEKDAY/WEEKEND

Time you go to bed?	____________________	
How long does it take you to go sleep?	______________hrs/min	
How many hours do you sleep each night?	____________________	
Do you take naps?	◯ Yes	◯ No
If yes, How many days per week?	____________________	
On the average, how long are the napes?	________________Hrs.	

BED PARTNER QUESTIONNAIRE

Ask someone familiar with your sleep to answer the following section about you (Spouse, parent, etc.)
Name of person filling out this section: ______________________________

Does the patient…..	**Answer Below**	
Stop breathing in his/her sleep	◯ Yes	◯ No
How often do the pauses in breathing occur?	◯ Every night ◯ Multiple times per night ◯ Occasionally	
Snore Heavily?	◯ Yes	◯ No
Snore continuously?	◯ Yes	◯ No
Snore every night?	◯ Yes	◯ No

Snore in the following positions:	◯ back ◯ left side ◯ right side ◯ all positions	
Kick and jerk frequently?	◯ Yes	◯ No
Sleep walk or talk during sleep?	◯ Yes	◯ No

Comments:

____
____
____
____
____

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SLEEP REVIEW OF SYSTEMS

DROWSINESS/SLEEPINESS

Are you frequently fatigued or drowsy during the day?	◯ Yes	◯ No
Have you had any accidents at work due to sleepiness?	◯ Yes	◯ No
Have you had any near traffic accidents due to sleepiness?	◯ Yes	◯ No

SNORING

Has anyone told you that you snore loudly?	◯ Yes	◯ No
Do you snore every night?	◯ Yes	◯ No
Do you snore almost continuously?	◯ Yes	◯ No
Have you awakened with a dry "cotton mouth"?	◯ Yes	◯ No
Has anyone told you that you quit breathing or hold your breath at night?	◯ Yes	◯ No
Have you ever awakened gasping for breath?	◯ Yes	◯ No
Do you ever wake at night with coughing, choking, or respiratory discomfort?	◯ Yes	◯ No
Do you have a dry throat when you wake up in the morning?	◯ Yes	◯ No
Do you have trouble breathing through your nose at night?	◯ Yes	◯ No
Do you have trouble breathing through your nose during the day?	◯ Yes	◯ No
Do you have morning headaches?	◯ Yes	◯ No
Weight change last 5 years?	Gained lbs_________	Lost lbs ___________

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REFLUX

Do you often wake with a sour taste or a burning sensation in your chest?	◯ Yes	◯ No

EXCESSIVE DAYTIME SOMNOLENCE

Do you have sudden episodes of sleep during the day?	◯ Yes	◯ No
Have you ever had periods in which you feel paralyzed while going to sleep or waking up?	◯ Yes	◯ No
Have you ever had visual hallucinations or dream-like mental images when falling to sleep?	◯ Yes	◯ No
Have you ever experienced sudden physical weakness during strong emotions? (Such as your mouth dropping open or legs going limp during laughter or anger)	◯ Yes	◯ No

CHILDHOOD

Did you have childhood sleep problems of any type?	◯ Yes	◯ No

If Yes, Describe:
____
____

RESTLESS LEGS SYNDROME/ PERIODIC LIMB MOVEMENT DISORDER

Do you frequently kick and jerk your legs at night while trying to fall asleep?	◯ Yes	◯ No
Do you have discomfort in your legs while trying to fall asleep?	◯ Yes	◯ No
Does moving your legs give you relief of discomfort?	◯ Yes	◯ No

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Do you have tingly or discomfort in your legs during the day?	◯ Yes	◯ No
Do you have discomfort in your legs when sitting for long periods?	◯ Yes	◯ No

INSOMNIA

Do you have difficulty initiating sleep at night?	◯ Yes	◯ No
Do you have difficulty staying asleep at night?	◯ Yes	◯ No
Do you have pain that bothers you at night?	◯ Yes	◯ No

PARASOMNIAS

Do you sleep walk?	◯ Yes	◯ No
Do you wet the bed at night?	◯ Yes	◯ No
Do you talk in your sleep?	◯ Yes	◯ No
Do you ever wake up screaming?	◯ Yes	◯ No
Do you have frequent nightmares?	◯ Yes	◯ No
Do you grind your teeth in your sleep?	◯ Yes	◯ No

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THE EPWORTH SLEEPINESS SCALE

Your Age: __________ Your Sex: (please circle) Male Female

How likely are you to doze off or fall asleep in the following situation in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

SITUATION	CHANCE OF DOZING
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 with circumstance permit	________________________
Sitting and talking to someone	________________________
Sitting quietly after a lunch without school	________________________
In a car, while stopped for a few minutes in traffic	________________________

Thank you for your cooperation.