SSMHealth
Sleep Services

SSM Health St. Joseph
Hospital - St. Charles

300 First Capitol Drive
St. Charles, MO 63301

phone: 636-947-5165, option 1

ssmhealth.com

# Pre-Sleep Questionnaire

Patient Name: _____ Date: _____

Form completed by: ☐ Patient ☐ Patient's family ☐ Sleep staff

## I. HEALTH HISTORY (check all that apply):

☐ Arthritis ☐ Chipped/loose teeth ☐ IV Device (port, PICC, etc.) ☐ Skin problems/wounds

☐ Back/Hip/Knee problems ☐ Diabetes ☐ Kidney disease ☐ Sleep apnea

☐ Bleeding problems ☐ Dialysis ☐ Pain prior to admission ☐ Stomach/Bowel problems

☐ Blood pressure problems ☐ Emotional problems ☐ Pregnant or lactating ☐ Stroke or TIA

☐ Blood transfusion ☐ Heart disease ☐ Exposure to toxic substances: _____

☐ Breathing problems ☐ Hepatitis ☐ Seizures

☐ Cancer ☐ Infection/Communicable disease (i.e. MRSA, HIV, C. Diff, etc.)

☐ Sensory loss: _____

☐ Other:_____

## II. PSYCHOSOCIAL / SPIRITUAL

Do you have any special concerns about being in the sleep lab? ☐ No ☐ Yes: _____

Any special religious/cultural factors related to your care? ☐ No ☐ Yes: _____

Sleeping problems: ☐ None ☐ Difficulty falling asleep ☐ Difficulty staying awake ☐ Other: _____

## III. NUTRITION

Are you on a special diet? ☐ No ☐ Yes: _____

Problem eating, chewing, swallowing? ☐ No ☐ Yes: _____

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## IV. NITIAL DISCHARGE PLANNING / HOME ENVIRONMENT

Live in: ☐ House ☐ Apartment ☐ Residential Housing ☐ Nursing Home ☐ Other: _____

Who do you live with? _____

Difficulty walking and/or getting out of bed or a chair? ☐ No ☐ Yes: _____

Does anyone help you at home now? ☐ No ☐ Yes Names/Agencies: _____

## V. ALLERGIES/MEDICATIONS (list allergies and describe reactions to drugs, food, tape, latex and others)

Allergy/Reaction: Allergy/Reaction: Allergy/Reaction:

_____ _____ _____

Will you be taking any medications brought from home during your sleep study test? ☐ No ☐ Yes: _____

_____

## VI. HOSPITALIZATIONS

Have you been hospitalized for illness or surgery in the past 6 months? ☐ No ☐ Yes: _____

_____

## VII. PRE-SLEEP QUESTIONS

Has today been an unusual day in any way? ☐ No ☐ Yes: _____

_____

How many hours of sleep did you get last night? _____

Did you take a nap today? ☐ No ☐ Yes (how many, what time and how long?): _____

Did you consume any alcoholic beverages today? ☐ No ☐ Yes (what time and how much?): _____

_____

Did you consume any chocolate or caffeinated beverages today? ☐ No ☐ Yes (what time and how much?): _____

_____

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Please list any medications you took today: _____

_____

Do you have any current physical complaints (pain, headache, nausea, etc.)? ☐ No ☐ Yes: _____

_____

**FOR CLINICIAN USE ONLY:**

**Arrival date: _____Arrival time: _____Mode: _____Accompanied by: _____**

**P:_____RR:_____SaO2:_____Pain assessment (0-10):_____**

**Mental status: (circle): Calm Anxious Withdrawn Alert Arousable Disoriented Unconscious Confused**

**Fall risk assessment (circle): No apparent fall risk Increased fall risk (explain): _____**

_____

**Ask patient how they feel now: ☐ Active, alert, wide awake ☐ Relaxed, awake ☐ Foggy, anxious to sleep**

**☐ Sleepy, prefer to be lying down ☐ Almost asleep, can't stay awake anymore**

**Clinical notes: _____**

_____

**Technologist signature:_____**