

GENERAL INFORMATION

Name: _____ Date: _____

Gender: M F Race: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

What is your primary problem with sleep? _____

How long have you had the sleep problem? _____ months _____ years

Medications: _____

List other problems with your sleep (indicate duration in months/years):

a. _____

b. _____

Have you had a sleeping problem diagnosed in the past? ____ Yes ____ No If yes, what was the problem and what treatment(s) was/were recommended? _____

Where was the diagnosis made? _____ Did the treatment(s) help? ____ Yes ____ No

SLEEP SCHEDULE AND SLEEP HYGEINE

What time do you usually **go to bed on weekdays** or days that **you work**? _____: _____ a.m. p.m.

What time do you usually **get up on weekdays** or days that **you work**? _____: _____ a.m. p.m.

What time do you usually **go to bed on weekends** or days that **you don't work**? _____: _____ a.m. p.m.

What time do you usually **get up on weekends** or days that **you don't work**? _____: _____ a.m. p.m.

How many hours do you usually sleep on **weekdays** or days that **you work**? _____ hours

How many hours do you usually sleep on **weekends** or days that **you don't work**? _____ hours

Are you usually refreshed by a nights sleep? ____ Yes ____ No

Are you unusually difficult to wake up in the morning? ____ Yes ____ No

If you could **set your own schedule**, what time would you go to bed and get up? _____: _____ _____: _____

How often do you take naps, and for **how long**, on the average: Number: Length:

Weekdays (work days) _____

Weekends (days not working) _____

Are you **refreshed by your naps**? ____ Yes ____ No

Do you currently do **shift work**? ____ Yes ____ No

If yes, do you have trouble sleeping when you are doing shift work? ____ Yes ____ No

INSOMNIA

(Answer the following question, with "night" meaning your major sleeping time.)

Which of the following do you do while in bed (circle all that apply)?:

Watch TV Read Listen to music Worry Other _____

What is the **average number of minutes it takes to fall asleep** at night? _____ minutes

Do you have awakenings during the night? ____ Yes ____ No

If yes, average # of times per night _____

INSOMNIA (Continued)

Why do you awaken (circle all that apply)?

Movement by bed partner Snoring by bed partner Pets Children Need to use bathroom Pain Noises
 My own snoring Shortness of Breath/Gasping/Choking Other: _____

How long are these periods of wakefulness when added together? _____ minutes per night

What do you do during these awakenings at night (circle all that apply):

Watch TV Read Listen to music Worry Computer Stay in bed Chores
 Move to another room Smoke Eat Other _____

Are you bothered by waking up too early and not being able to get back to sleep? _____ Yes _____ No

If yes, what is the average number of nights per week? _____ nights per week

How many nights a week do you feel you have a sleep problem? _____ nights per week.

EXCESSIVE SLEEPINESS AND SLEEP-RELATED BREATHING SYMPTOMS

How likely are you to **doze off or fall asleep** in the following situations, **in contrast to just feeling tired**? This refers to your usual way of life in recent times. 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 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theatre 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 minutes in traffic or at a stop light	_____

How long have you had excessive sleepiness in the daytime? _____ months/years (circle one) _____ N/A

Have you had an accident or near-miss accident because of **sleepy driving**? _____ Yes _____ No

Have you ever felt sudden **muscle weakness** when you laughed, got angry, or were surprised? _____ Yes _____ No

Have you ever been **unable to move your body** just as you were falling asleep or waking up? _____ Yes _____ No

Do you have difficulty **distinguishing your dreams from reality**? _____ Yes _____ No

If yes, to any of the above, Please describe: _____

Do you awaken (circle all that apply):

With morning headaches With a dry mouth/sore throat Feeling unrefreshed With great difficulty

Have you been told that you (circle all that apply):

Snore (circle: mildly or loudly) Snore while sleeping upright Stop breathing during sleep

Do you have or had any of the following (circle all that apply):

Allergies	Runny nose	Sinus infections	Difficulty breathing through your nose	Asthma
Septoplasty	Tonsillectomy	Adenoidectomy	Other Surgery on your upper airway	COPD
Acid Reflux	Hiatal Hernia	Encephalitis	Had a convulsion (seizure, epilepsy)	Meningitis
Mononucleosis	Hypertension	Heart Failure	Had serious injury to your head	Stroke

Over the past *ONE month*, how much of a **problem** were the following conditions for you?

Please **circle** the most correct response

	Not a Problem	Very Mild Problem	Moderate Problem	Fairly Bad Problem	Severe Problem
1. Nasal congestion or stuffiness	0	1	2	3	4
2. Nasal blockage or obstruction	0	1	2	3	4
3. Trouble breathing through my nose	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

MOVEMENT

- Are your bed covers extremely messy in the morning when you wake up? _____ Yes _____ No
- Do you awaken yourself or others by kicking your legs during the night? _____ Yes _____ No
- Has your bed partner ever complained of your legs kicking during the night? _____ Yes _____ No
- Do you have a **restless sense of discomfort** (crawling sensation) in your legs during the waking hours or as you are trying to fall asleep? _____ Yes _____ No
- Do you exercise regularly? _____ Yes _____ No

PARASOMNIAS

Do you now or have you in the past (circle all that apply):

- | | | |
|--|--|---|
| Grind or clench you teeth | Walk in your sleep | Have nightmare or night terrors |
| Fallen out of bed | Wet the bed (as an adult) | Eat in your sleep |
| Have unusual movements in sleep | Physically act out dreams | Injured yourself or others during sleep |
| Performed a complex activity (eg. Driving a car,) without memory | Undesirable sexual behavior during sleep | |

If yes, how frequently? _____ per week/month/year (circle one) **What age did they begin?** _____ years

Please describe: _____

FAMILY AND MEDICAL HISTORY

Did you have any sleep problem as a child? _____ Yes _____ No **Circle all that apply:**

- Snoring Sleep Apnea Restless Legs Syndrome Sleep Walking Insomnia Excessive Sleepiness

Do other members of your immediate family have any sleep disorders? _____ Yes _____ No **Circle all that apply:**

- Snoring Sleep Apnea Restless Legs Syndrome Sleep Walking Excessive Daytime Sleepiness

Insomnia Injuries during sleep Other: _____

FAMILY AND MEDICAL HISTORY (Continued)

(NEXT FOUR QUESTIONS ARE FOR WOMEN ONLY)

Have your sleep/wake problems ever varied according to the stage of your menstrual cycle? Yes No
 Are you pregnant? Yes No Are you past menopause (change of life)? Yes No
 If so, did your sleep complaints vary during or after your menopause? Yes No

PSYCHOLOGICAL HISTORY

Do you feel depressed? Never Rarely Occasionally Frequently Always
 Has your sleep problem contributed to a change in mood or personality? Yes No If yes, describe:

 Have you EVER seen a psychiatrist or any other type of counselor? Yes No Currently? Yes No
 Have you been abused [physically, sexually or emotionally (circle)] during Childhood or Adulthood (circle)?

SOCIAL HISTORY

Please indicate the number of cups per day consumed of the following beverages:

Caffeinated Coffee (8 oz) Caffeinated Tea (8 oz) Caffeinated Soft Drinks (12 oz)

Have you EVER taken prescription stimulants or over-the-counter stimulants? Yes No

Do you function satisfactorily during the day when taking stimulants? Yes No

Do you currently smoke marijuana or take any other mood-altering illicit drugs? Yes No

If yes, what and how often: _____

Did you ever drink alcohol? Yes No Do you currently drink alcohol? Yes No

If yes, on the average, how many alcoholic drinks do you take on **weekdays** (working days)?

(one glass of wine, one shot of liquor, or one beer = one drink) per day

On the average, how many alcoholic drinks do you take on **weekends** (non-working days)? per day

Have you EVER used alcohol to get to sleep? Yes No

Have you EVER had the following problems in association with drinking alcoholic beverages (circle all that apply)?

Blackouts	D.T.'s shakes, hallucinations
Arrests for drunken driving	Family complaints or personal concerns about your drinking
Late or missed work or appointments	Violent or over-excited behavior
Detoxification or other treatment	Automatic behavior (carrying out actions without being aware of what you are going)

Are you in danger of losing your job because of your sleep problem? Yes No

Additional comments regarding your sleep: _____

Thank you for your cooperation in completing this questionnaire.

Completed by: _____ Relationship: _____