SLEEP DISORDERS QUESTIONNAIRE

Date: _____

Name: _____
Last First Middle

Age: _____ Date Of Birth: _____

Height: _____ Weight: _____

1. Please describe your sleep concerns in the space below including when it started.
_____
_____
_____
_____
_____
_____

2. Have you previously been evaluated in a sleep facility or treated for any sleep problems? **Yes** **No**
Testing Facility: _____Date of test: _____
What were the results? _____

3. List any present health problems and treatments:
_____
_____
_____
_____

4. Work day/Weekday
Bedtime: _____ Awakening Time:_____
How long does it take you to fall asleep? _____
How many times do you wake up on an average night? _____
What wakes you up? _____
How long are you awake during these awakenings? _____
How much total sleep do you get these nights? _____

5. Day off/Weekend
Bedtime: _____ Awakening Time:_____
How long does it take you to fall asleep? _____
How many times do you wake up on an average night? _____
What wakes you up? _____
How long are you awake during these awakenings? _____
How much total sleep do you get these nights? _____

6. Do you believe you have insomnia? **Yes** **No**

7. In what position do you sleep? **Back** **Side** **Front** **Flat** **Head elevated**

8. Do you use oxygen at home? **Yes** **No**. If yes, how much? _____

9. Do you wake up short of breath? **Yes** **No**. If yes, describe: _____
_____

10. Do you wake up gasping or choking? **Yes** **No**. If yes, describe: _____
_____

11. Do you wake up with a headache? **Yes** **No**. If yes, how often? _____

12. Do you snore? **Yes** **No**. If yes, how much? **Mild** **Moderate** **Severe**

13. Have you been told that you stop breathing in your sleep? **Yes** **No** If yes: **Frequent** **Rare**

14. Do you have a restless or uncomfortable feeling in your legs when lying down? **Yes** **No**
    If yes, does this feeling contribute to insomnia? **Yes** **No**
    If yes, how often? **Rarely** **Occasionally** **Frequently**

15. Do you kick in your sleep? If yes, how much? **Mild** **Moderate** **Severe**

16. How many cups of regular coffee (not decaf) do you drink per day? _____

17. How many glasses of tea (not decaf) do you drink per day? _____

18. How much soda (not decaf) do you drink per day? _____

19. How much chocolate do you eat each day? _____

20. How much alcohol do you drink? _____

21. Do you smoke or use nicotine containing products? **Yes** **No**
    If yes, how much per day? _____

22. Do you take medications to help you sleep (prescription or over-the-counter)? **Yes** **No**
    If yes, give name and dose: _____
    In a <u>week</u> how often do you take it? **Less than twice/week** **2-5 times/week** **6-7 times/week**

23. Do you take medications to help you stay awake?
    If yes, give name and dose: _____

24. Are you **Sleepy** **Fatigued** **Tired** during the day? (circle all that apply)

25. Have you ever fallen asleep eating, talking or driving? **Yes** **No**
    If yes, how often? **Rarely** **Occasionally** **Frequently**
    If yes, explain: _____
    _____

26. How many times per week do you take a nap on purpose? _____
    How long do you sleep for? _____
    How do you feel upon awakening? **Great** **OK** **Tired**

27. How many times per week do you fall asleep in quiet situations (TV, reading, etc.)? _____
    How long do you sleep for? _____
    How do you feel upon awakening? **Great** **OK** **Tired**

28. Do you have vivid dreams within a few minutes of falling asleep? **Yes** **No**
    If yes, how often? **Rarely** **Occasionally** **Frequently**

29. Have you ever woken up with your whole body temporarily paralyzed? **Yes** **No**
    If yes, how often? **Rarely** **Occasionally** **Frequently**

30. Have you ever had sudden weakness/loss of strength, particularly after anger or laughter? **Yes** **No**
    If yes, how often? **Rarely** **Occasionally** **Frequently**
    If yes, explain:_____
    _____

31. Do you have any unusual behaviors while sleeping?
    If yes, explain:_____
    _____
    _____
    _____
    _____
    _____

32. Do you have high blood pressure? **Yes** **No**
33. Are you being treated for high blood pressure? **Yes** **No**
34. Have you ever had a stroke? **Yes** **No**
35. Have you ever had memory loss? **Yes** **No**
36. Have you ever had a heart attack? **Yes** **No**
37. Do you have Coronary Artery Disease? **Yes** **No**
38. Do you have depression? **Yes** **No**
39. Do you have mood swings or bipolar disorder? ? **Yes** **No**
40. Please describe any additional information that you feel is relevant to your sleep._____
    _____
    _____
    _____
    _____

EPWORTH SLEEPINESS SCALE

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 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

1. Sitting and Reading. _____

2. Watching T.V. _____

3. As a passenger in a car for an hour without a break. _____

4. Lying down to rest in the afternoon. _____

5. Sitting, inactive in a public place. _____

6. Sitting and talking to someone. _____

7. Sitting quietly after lunch without alcohol. _____

8. In a car, while stopped for a few minutes in traffic. _____

Total _____