



Comprehensive Neurology and Sleep Medicine, P.A.

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Name: _____ DOB: _____ Today's date: _____

Please answer all questions as accurately as possible, since your answers will help diagnose and treat your complaints. Please answer the following questions with your sleeping partner as completely and accurately as you can. Bring this questionnaire with you on your first visit. Please ask your sleeping partner to rate your sleep when requested below.

Note: If you have had a recent sleep study and completed this questionnaire at the time of your sleep study, you do not have to complete this questionnaire. Please ask our receptionist to obtain a copy of the one that you previously completed.

GENERAL SLEEP INFORMATION:

- 1. How long have you had a sleep problem?... ___ wks ___ mos ___ yrs
Sleep partner's response ... ___ wks ___ mos ___ yrs
2. How many nights each week do you have a sleep problem?... ___ nights
Sleep partner's response ... ___ nights
3. What time do you usually go to bed?... ___ am ___ pm
Sleep partner's response ... ___ am ___ pm
4. What time do you usually leave bed to start your morning routine?... ___ am ___ pm
Sleep partner's response ... ___ am ___ pm
5. How many hours do you sleep on an average night?... ___ hours
Sleep partner's response ... ___ hours
6. How many times do you wake up during an average night?... ___ times
Sleep partner's response ... ___ times
7. On average, how long altogether are you awake during the night?... ___ minutes
Sleep partner's response ... ___ minutes
8. Do you take naps? yes no What times? ___ Average length of nap? ___

AFTER DECIDING TO GO TO SLEEP AT NIGHT:

- 9. Do you have difficulty getting to sleep?... yes no
10. How long does it usually take you to fall asleep?... ___ minutes
11. Do you experience pain or physical discomfort?... yes no
12. Do you feel unable to relax?... yes no

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13. Do you have odd sensations or restlessness in your legs as you fall asleep?..... yes no

14. Do you have twitches or movements in your legs or arms as you fall asleep?..... yes no

15. Check which of the following techniques you use to help fall asleep:

- medication baths, hot tubs, etc biofeedback
- exercise hypnosis (tapes, etc) special diets, foods, drinks or vitamins
- relaxation techniques mental imagery (counting sheep, etc)

AFTER FALLING ASLEEP:

16. Do you have any unusual sleep behavior? yes no

Sleeping partner's response yes no

If yes, please

describe: _____

17. Do you have problems with nightmares?..... yes no

For questions below that require a simple yes or no answer, circle your choice. For questions with a choice of numbers 1 to 5, please circle the number which best describes your condition using the grading system below:

- 1 = no problem, never occurs**
- 2 = mild problem, rarely occurs**
- 3 = moderate problem, happens occasionally**
- 4 = moderately severe problem, occurs frequently**
- 5 = severe problem, occurs very frequently**

HOW OFTEN IS YOUR SLEEP DISTURBED DURING THE NIGHT OR AT SLEEP ONSET BECAUSE OF:

- 18. heat? 1 2 3 4 5
- 19. cold? 1 2 3 4 5
- 20. light? 1 2 3 4 5
- 21. any type of noise? 1 2 3 4 5
- 22. not being in your usual bed? 1 2 3 4 5
- 23. noise or movement of your bed partner? 1 2 3 4 5
- 24. some other environment factor? 1 2 3 4 5

HOW OFTEN IS YOUR SLEEP DISTURBED BECAUSE OF:

- 25. asthma? 1 2 3 4 5
- 26. a persistent cough? 1 2 3 4 5
- 27. shortness of breath while lying flat? 1 2 3 4 5
- 28. "gas" in your stomach, indigestion or heartburn? 1 2 3 4 5
- 29. "heartburn", throat burning, choking or gagging? 1 2 3 4 5
- 30. awakening due to hunger? 1 2 3 4 5
- 31. awakening due to thirst? 1 2 3 4 5
- 32. awakening with an urgent desire to urinate? 1 2 3 4 5

HOW OFTEN DO YOU:

- 33. usually get up to urinate during the night? 1 2 3 4 5
- 34. have nasal congestion, stuffiness, or blockage during the night? 1 2 3 4 5
- 35. notice your heart pounding or beating irregularly during the night? 1 2 3 4 5
- 36. eat excessively during the night? 1 2 3 4 5
- 37. snore in any way during sleep? 1 2 3 4 5
- Sleeping partner's response..... 1 2 3 4 5

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- 38. snore loudly and disruptively? 1 2 3 4 5
 Sleeping partner's response..... 1 2 3 4 5
- 39. hold your breath or stop breathing during sleep? 1 2 3 4 5
 Sleeping partner's response 1 2 3 4 5
- 40. wake up gasping for breath or feeling unable to breathe?..... 1 2 3 4 5
 Sleeping partner: Please describe the breathing problems: _____

DURING THE DAY, HOW MUCH DIFFICULTY HAVE YOU HAD WITH:

- 41. fatigue, tiredness, exhaustion or lethargy? 1 2 3 4 5
- 42. accidents occurring as a result of falling asleep while driving? 1 2 3 4 5
- 43. daytime hallucinations or dreaming?. 1 2 3 4 5
- 44. sleep paralysis or not being able to move when first waking up? 1 2 3 4 5
- 45. sudden weakness if surprised, upset or laughing hard?..... 1 2 3 4 5

46. **How likely are you to doze or fall asleep in the following situations**, in contrast to feeling just 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

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 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	_____

47. **Check which one of the following statements best describes how sleepy you are during the day?**

- _____ I have no unwanted sleepiness or involuntary sleep episodes.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require little attention. Examples include sleepiness that is likely to occur while watching television, reading, or traveling as a passenger. Symptoms produce only minor impairment of social or occupational function.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require some attention. Examples include uncontrolled sleepiness that is like to occur while attending activities such as concerts, meetings or presentations. Symptoms produce moderate impairment of social or occupational function.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require more active attention. Examples include uncontrolled sleepiness while eating, during conversation, walking, or driving. Symptoms produce a marked impairment of social or occupational function.

GENERAL HEALTH:

- 48. What kind of work do you do? _____
- Do you enjoy it? yes no
- How many weeks of vacation are taken a year? _____ Date of last vacation: _____
- Have you ever worked shift work: yes no If yes, please describe: _____

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49. Do you exercise adequately? yes no How do you exercise? _____

50. On the average, how many of the following do you use each day?

Natural coffee	_____	Decaf coffee	_____
Tea	_____	Chocolate	_____
Colas with caffeine	_____	Alcoholic beverages	_____
Tobacco products	_____		

51. Check any of the follow that apply to you:

nightmares headaches stomach problems
 poor appetite depression bad home conditions
 unable to relax dizziness shyness
 difficulty with decisions feel panicky suicide ideas
 palpitations fainting poor concentration
 bowel disturbance feel tense poor memory

52. Do you now see a psychiatrist or a mental health worker? yes no

If yes, please describe: _____

53. Have you ever been treated for alcoholism or drug abuse?..... yes no

If yes please provide details: _____

54. Is there any additional information that you feel may be important pertaining to your sleep study that has not been covered by this questionnaire. If yes, please explain: _____

55. Year of your last physical exam: _____ Physician's name: _____

Address: _____

Phone: _____

Brief results of exam: _____

56. Have you had bariatric surgery? yes no

57. Have you had sleep studies done in the past? yes no

If yes, when and where were the studies done? _____

If you were previously diagnosed with obstructive sleep apnea, please complete this section:

58. In what year was your sleep apnea diagnosed? _____

59. Were you started on CPAP? yes no

If yes, when were you started on CPAP? _____

60. Do you use a CPAP now? yes no

If not, why? _____

61. Have you had surgery for sleep apnea? yes no

62. Have you used a dental appliance for sleep apnea? yes no