



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.

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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? \_\_\_

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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

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: \_\_\_\_\_

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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

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: \_\_\_\_\_
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**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.

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**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