Comprehensive Neurology and Sleep Medicine, P.A.

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SLEEP QUESTIONNAIRE

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

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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
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 <u>one</u> 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: ____________________
____

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