Please fill in and bring with you to your appointment in the sleep laboratory or fax it ahead of time to 480-603-0620.

# SLEEP SYMPTOMS QUESTIONNAIRE

**Name** _____ **Sex M F Today's Date** _____

**Birth date** _____ **Age** _____ **Height** _____ **ft.** _____ **ins. Weight** _____ **lbs.**

**Your Doctor** _____ **Neck Size (if known)** _____ **inches**

**Day telephone** _____ **Evening telephone** _____

**Type of work** _____ **Usual work hours** _____

**Do you do shift work or do your work hours vary? YES NO** If so, how? _____

_____

**What is the main problem with your sleep?** _____

_____

Have you had a sleep laboratory study before? **YES NO**

If yes, where and when? _____

Was any treatment prescribed since your last study? **YES NO**

Please explain. What effects did treatment have? _____

_____

Any other treatment you use for your sleep problems (e.g. medication, CPAP, oxygen, or other)? **YES NO**

If so, what treatment and how often do you use it? _____

Have you been in the hospital recently? **YES NO**

When, where and reason? _____

## • Your Medical History

Medicines you are allergic to _____

Current medicines **and doses**

| Name | Dose | Time You Take It | Purpose of the medicine |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(continue on next page if needed)

Check if you have or have had in the past:

_____ high blood pressure
_____ diabetes
_____ heart problems (specify) _____
_____ congestive heart failure
_____ lung problems (specify) _____
_____ frequent coughing
_____ frequent sinus problems
_____ shortness of breath with exercise
_____ tonsils out
_____ adenoids out
_____ nasal or sinus surgery
_____ pollen, dust or animal allergies

_____ indigestion, gas or heart burn
_____ an ulcer or hiatal hernia
_____ seizures
_____ a stroke or TIA
_____ a head injury
_____ arthritis
_____ fibromyalgia
_____ a broken nose
_____ underactive thyroid
_____ overactive thyroid
_____ depression
_____ anxiety

Describe any problems checked and **list other important medical & surgical history**: _____

_____

Any family history of sleep problems? _____

## • Your Sleep Routines

| | | |
|---|---|---|
| Do you sleep alone? | **YES** | **NO** |
| Do you have trouble relaxing and feeling ready for bed? | **YES** | **NO** |
| Do you go to sleep with the TV on or leave it on during the night? | **YES** | **NO** |
| Do you sleep in a recliner or with the head of your bed elevated? | **YES** | **NO** |
| Do you feel rested in the morning? | **YES** | **NO** |

What position(s) do you sleep in? _____

**Please fill in the boxes in the table below.** We want to know what your sleep schedule is usually like, and also how it might vary. Please write down the time you *usually* get into bed, along with the earliest and latest times you might get into bed. Do the same for the time you turn out your light and so on.

| | Usual | Earliest | Latest |
|---|---|---|---|
| **Time you get into bed** | | | |
| **Lights out time** | | | |
| **Minutes to get to sleep** | | | |
| **Wake up time** | | | |
| **Get out of bed time** | | | |

Do the times you recorded in this table change on the weekends? **YES** **NO**

If so, what changes and how much? _____

How many times do you wake up on an average night? _____

How long does it take you to get back to sleep after waking up? _____

How many naps do you take each day and how long do they last? _____

Patient Name: _____

## • Problems when FALLING ASLEEP

**A.** Are you bothered by feelings in your legs or arms that are "creepy, crawly," or tingling/itching, or aching or that make you feel you need to keep moving or stretching your legs or arms? **YES** **NO**

**B.** Do you feel like you have to rub your legs or walk around to get them comfortable? **YES** **NO**

If yes to either **A** or **B**, does moving or walking *temporarily* relieve the sensation? **YES** **NO**

Do you ever suddenly become awake or alert? **YES** **NO**

Do you have vivid, dream-like scenes even when not totally asleep? **YES** **NO**

Do you ever suddenly feel like somebody or something is in the room? **YES** **NO**

Do you have:

- Racing thoughts? **YES** **NO**
- Pain, discomfort or muscle tension? **YES** **NO**

When you are going to sleep do you feel:

- Worried? **YES** **NO**
- Sad or depressed? **YES** **NO**

Please explain any "YES" answers from above: _____

_____

## • Problems DURING SLEEP

Do you snore? **YES** **NO**

Is your snoring loud enough to disturb your spouse or bed partner? **YES** **NO**

Does it disturb others in other rooms? **YES** **NO**

Have you been told you stop breathing during sleep? **YES** **NO**

Are you a violent sleeper? (thrashing about, throwing off covers, etc.) **YES** **NO**

Have you ever injured yourself or someone else while you were asleep? **YES** **NO**

Has there ever been any ***risk*** of injury? **YES** **NO**

Do you:

- Awaken with chest pain? **YES** **NO**
- Awaken short of breath? **YES** **NO**
- Awaken screaming or violent? **YES** **NO**
- Suddenly awaken; remain confused, disoriented for several minutes? **YES** **NO**
- Sleepwalk? **YES** **NO**
- Eat or fix food without remembering it in the morning? **YES** **NO**
- Grind your teeth during your sleep? **YES** **NO**
- Kick or hit your spouse or bed partner during sleep? **YES** **NO**
- Fall out of bed or have unusual movements during sleep? **YES** **NO**

Please explain any "YES" answers from above: _____

_____

My sleep is frequently disturbed by: (check all that are true for you)

| | | | |
|---|---|---|---|
| _____ | heat or cold | _____ | indigestion, gas or heartburn |
| _____ | light | _____ | choking |
| _____ | noise | _____ | hunger (need to get up and eat) |
| _____ | bed partner/child care | _____ | thirst |
| _____ | asthma | _____ | need to urinate |
| _____ | cough | _____ | leg discomfort |
| _____ | shortness of breath | _____ | frightening dreams or nightmares |

Other: _____

Patient Name: _____

## • Problems with WAKING FOR YOUR DAY

Do you awaken with:

| | | |
|---|---|---|
| Headaches? | **YES** | **NO** |
| Fogginess or incoordination? | **YES** | **NO** |
| A dry mouth? | **YES** | **NO** |
| Drooling? | **YES** | **NO** |
| Nausea? | **YES** | **NO** |
| The experience of being temporarily paralyzed? | **YES** | **NO** |

Do you:

| | | |
|---|---|---|
| Have an unusually hard time waking up? | **YES** | **NO** |
| Have dream-like images even when you know you are awake? | **YES** | **NO** |

## • Problems in the DAYTIME

Have you ever had a strong emotion like laughing hard or getting angry or upset and then suddenly gotten physically weak or even fallen? **YES** **NO**

Have you ever realized that you do not know how you got where you are or that you have no memory for a task you have just completed? **YES** **NO**

Please explain any "YES" answers from above: _____

_____

## EPWORTH SLEEPINESS SCALE

**In the following situations, how likely would you be to actually doze off? Even if you have not done some of these things recently, try to work out how they would have affected you in recent weeks or months. Use the following scale and circle the <u>most appropriate number</u> for each situation:**

**0 = would never fall asleep** **2 = moderate chance of falling asleep**

**1 = slight chance of falling asleep** **3 = high chance of falling asleep**

| **SITUATION** | | | | |
|---|---|---|---|---|
| 1. Sitting and reading | **0** | **1** | **2** | **3** |
| 2. Watching TV | **0** | **1** | **2** | **3** |
| 3. Sitting, inactive in a public place (e.g., a theater or meeting) | **0** | **1** | **2** | **3** |
| 4. As a passenger in a car for an hour without a break | **0** | **1** | **2** | **3** |
| 5. Lying down to rest in the afternoon when circumstances permit | **0** | **1** | **2** | **3** |
| 6. Sitting down and talking to someone | **0** | **1** | **2** | **3** |
| 7. Sitting quietly after a lunch | **0** | **1** | **2** | **3** |
| 8. Driving a car, while stopped for a few minutes (e.g., at traffic light) | **0** | **1** | **2** | **3** |
| **TOTAL SCORE** | | | | |

Are there any other situations in which you fall asleep when you don't mean to? (e.g., at parties, at the dinner table, on the phone, etc.?) _____

_____

Patient Name: _____

## • Health Habits

Are you currently using tobacco? **YES** **NO**

**Circle:** Cigarettes Cigars Pipe or Chewing tobacco How much/often? _____

Have you ever used tobacco? **YES** **NO**

**Circle:** Cigarettes Cigars Pipe or Chewing tobacco How long ago did you stop? _____

On an average, how much of these beverages do you drink:

| | During a typical week | During a typical day | Within 2 hours of bedtime |
|---|---|---|---|
| Coffee (caffeinated) | _____ cups | _____ cups | _____ cups |
| Tea (caffeinated) | _____ cups | _____ cups | _____ cups |
| Soda (caffeinated) | _____ cans | _____ cans | _____ cans |
| Beer | _____ cans/bottles | _____ cans/bottles | _____ cans/bottles |
| Wine | _____ glasses | _____ glasses | _____ glasses |
| Other alcoholic drinks | _____ glasses | _____ glasses | _____ glasses |

Do you get any physical exercise: **YES** **NO**

If so, what kind and how often? _____

Please describe anything else that you think may be important for us to understand any problems that you have with sleep or sleepiness. This will greatly assist in contributing to your treatment. Thank you.

Please explain any "YES" answers from above: _____

_____

_____

_____

_____

_____

_____

_____

**(11/1/08)**

Patient Name: _____