Please fill in and bring with you to your appointment in the sleep laboratory or fax it ahead of time to 505-327-5597.

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

Question		
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

Question		
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: ______________________________