

SLEEP QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital Status: Single Married Divorced Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in the appropriate areas.

My main sleep complaint(s) is:

- Trouble sleeping at night For how many months/years? _____
- Being sleepy all day For how many months/years? _____
- Snoring For how many months/years? _____
- Unwanted behaviors during sleep, *please explain:* _____
- Other, *please explain:* _____

Sleep Pattern

	<u>Work Days (Weekdays)</u>	<u>Off Days (Weekends)</u>
Typical Bedtime:	_____ am/pm	_____ am/pm
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do During nighttime awakening(s); i.e. restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ am/pm	_____ am/pm
Desired wake up time	_____ am/pm	_____ am/pm

	<u>Work Days (Weekdays)</u>	<u>Off Days (Weekends)</u>
How do you usually awaken; i.e. alarm clock?	_____ am/pm	_____ am/pm
Typical time you get out of bed:	_____	_____
Number of naps per day:	_____	_____
Length & time of naps:	_____	_____

Please check all of the following statements that are true about your sleep:

Sleep Habits

- I usually watch TV or read in bed prior to sleep
- I drink alcohol prior to bedtime
- I smoke prior to bedtime or when I awaken during the night
- I eat a snack at bedtime
- I have thoughts that start racing through my mind when I try to fall asleep
- I eat if I wake up during the night
- I typically wake up from sleep to go to the bathroom
- I often wake up during the night after falling asleep
- I am unable to return to sleep easily if I wake up during the night
- I wake up early in the morning and I am still tired, but unable to return to sleep
- I have had nightmares as an adult
- I wake up suddenly gasping for breath, unable to breathe
- I sweat a great deal during sleep
- I cannot sleep on my back

Restlessness

- I have uncomfortable feelings in my legs and/or arms when I lie down at night
- I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- I am a restless sleeper
- I have been told that I kick or jerk my legs and/or arms during sleep
- I have a hard time falling asleep because of my leg movements
- I have talked in my sleep as an adult
- I have walked in my sleep as an adult
- I grind my teeth in my sleep

Daytime Sleepiness

- I take daytime naps
- I have a tendency to fall asleep during the day
- I have had "blackouts" or periods when I am unable to remember what just happened
- I have fallen asleep while driving
- People notice that my jaw and/or face goes slack when I laugh, am surprised, or have a strong emotion
- I performed poorly in school because of sleepiness
- I have had injuries as the result of sleepiness
- I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- I have had an inability to move while falling asleep or when waking up
- I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- I drink caffeinated beverages during the day: _____ cups/bottles/cans per day

Habits

Do you smoke? Yes No

If Yes:	<u>What?</u>	<u>Amount per Day</u>	<u>For How Many Years</u>
	<input type="checkbox"/> Cigarettes	_____ pack(s)	_____ years
	<input type="checkbox"/> Cigars	_____ cigars	_____ years
	<input type="checkbox"/> Tobacco	_____ pipes	_____ years

Do you drink alcohol? Yes No

If Yes:	<u>What?</u>	<u>Frequency</u>	<u>Amount per Week</u>
	<input type="checkbox"/> Beer	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ cans/week
	<input type="checkbox"/> Wine	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ glasses/week
	<input type="checkbox"/> Liquor	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ shots/week

Social History

- Sleep alone
- Share a bed with someone
- Share a bedroom, but have separate beds
- Share a dwelling, but have separate bedrooms

Employment Status: Employed Unemployed Retired

- My job required driving a vehicle
- I work with dangerous equipment or substances
- I am a shift worker on rotating shifts
- I am a permanent or long-term, third-shift worker
- I am currently a student

Medical History

Vital Statistics

What is your: Height? _____ feet _____ inches Weight? _____ pounds Neck size? _____

What was your weight: 1 year ago? _____ pounds Five years ago? _____ pounds

Current Medications

<u>Medication</u>	<u>Dose</u>	<u>#Times per</u>	<u>Day</u>	<u>Medication</u>	<u>Dose</u>	<u># Times Per</u>	<u>Day</u>
_____				_____			
_____				_____			
_____				_____			
_____				_____			

Allergies: _____

Past Sleep Evaluation & Treatment

- I have had a previous sleep disorder evaluation (*please bring all former studies & current equipment with you to your first appointment*)
- I have been prescribed a CPAP or bi-level PAP machine for home use
- I have had surgical treatment for a sleep disorder. Which one?_____ When?_____
- I have previously been prescribed medication for a sleep disorder. Which one?_____
- I have previously been treated for a sleep disorder

Past Medical History

- | | |
|---|---|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression or severe anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Stomach or colon problems | <input type="checkbox"/> Chemical dependency or abuse |
| <input type="checkbox"/> COPD/asthma | <input type="checkbox"/> Are you on oxygen therapy? |
| <input type="checkbox"/> Reflux | |
| <input type="checkbox"/> Fibromyalgia | |
| <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> TIA "Light Stroke" | |
| <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Joint problems (arthritis) | |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Allergies | |

Female

- Premenstrual problems
- Menopause

Male

- Prostate problems
- Erectile dysfunction/impotence

List other Past Medical Problems and the dates

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Surgeries and the corresponding years

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check any of the following symptoms you have had in the past 12 months:

- | | | | | | |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|--|
| <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Irregular or sudden: fast heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Passing out | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing or food "sticking" |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden loss of vision or strength | <input type="checkbox"/> | <input type="checkbox"/> | Frequent heartburn/indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to speak | <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding/black stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss or ringing in ear(s) | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating/incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | Urinating more than 2 times per night |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Pain in joints or bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Unusual bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling in feet or ankles | <input type="checkbox"/> | <input type="checkbox"/> | Change in wart, mole, or skin growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain: tightness or pressure | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss of more than 5-10 lbs. |

Family History

Has an immediate blood relative had any of the following?

- | | | | | | | | |
|--------------------------|--------------------------|-----------------|-----------------|--------------------------|--------------------------|--------------------|-----------------|
| <u>Yes</u> | <u>No</u> | | <u>Relation</u> | <u>Yes</u> | <u>No</u> | | <u>Relation</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Depression | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Narcolepsy | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | _____ |

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or meeting)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____

BERLIN QUESTIONNAIRE

SLEEP EVALUATION

1 Complete the following:

Age _____ Male/Female _____

Category 1

2 Do you snore?

- Yes
- No
- Don't Know

If you Snore:

3 Your Snoring is?

- Slightly louder than breathing
- As loud as talking
- Louder than talking
- Very loud, can be heard in adjacent rooms

4 How often do you snore?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

5 Has your snoring ever bothered other people?

- Yes
- No

6 Has anyone noticed that you quit breathing during your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

Category 2

7 How often do you feel tired or fatigued after your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

8 During your wake time, do you feel tired, fatigued or not wake up to par?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

9 Have you ever nodded off or fallen asleep while driving a vehicle?

- Yes
- No

If yes, how often does it occur?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

Category 3

10 Do you have high blood pressure?

- Yes
- No
- Don't Know

Height: _____ **Weight:** _____

NOTE: If you have regular sleep habits you do not need to fill this page out.

Name: _____

INSTRUCTIONS: Complete these logs in the morning and the evening. Do not complete them during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your doctor.

1. Leave the boxes BLANK to show when you are awake.
2. SHADE or color the boxes to show when you are asleep.
3. ARROW DOWN -↓- when you lie down to sleep.
4. ARROW UP -↑- when you wake up (include naps).
5. "M" for meals, "S" for snacks, "C" for caffeine, "A" for alcohol.
6. Include notes below each week or on the back.

EXAMPLE:

	6am	8am	10am	Noon	2pm	4pm	6pm	8pm	10pm	Midnight	2am	4am	6am
9/15/2008		↑C			M↓	↑		A S	↓				↑S↓

FIRST WEEK

Date	6am	8am	10am	Noon	2pm	4pm	6pm	8pm	10pm	Midnight	2am	4am	6am

SECOND WEEK

Date	6am	8am	10am	Noon	2pm	4pm	6pm	8pm	10pm	Midnight	2am	4am	6am

BED PARTNER QUESTIONNAIRE

NOTE: If you have a bed partner, please ask them to fill this part out for you.

Name of Patient: _____ **Date:** _____

Check any of the following behaviors that you have observed the patient doing **while asleep**:

- Loud snoring
- Light snoring
- Twitching of legs or feet
- Pauses in breathing
- Grinding teeth
- Sleep talking
- Sleepwalking
- Bed wetting
- Sitting up in bed while still asleep
- Head rocking or banging
- Kicking with legs
- Getting out of bed while still asleep
- Biting tongue
- Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night, and whether it occurs every night. _____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud “snorts” that you may have noticed. _____
