

Sleep Questionnaire - PACIFIC SLEEP CENTER

Please complete this questionnaire in its entirety and bring it to your appointment to ensure a thorough evaluation. Please get input from someone who shares your bedroom if possible. This information will become a part of your confidential medical record.

Name: _____

Date: _____

What is the main reason you have decided to come in for a sleep evaluation?

What time do you usually go to bed (average) on a weekday (workday or school day)? _____ AM PM

What time do you usually attempt to fall asleep (average) on these days? _____ AM PM

How long does it usually take you to fall asleep once you begin trying (average) on these days? _____ Min Hrs

How often have you noticed the following problems when you are trying to go to sleep? (check one answer for each)	<i>Never</i>	<i>Not in past month</i>	<i>Less than once/wk</i>	<i>1-2 times/wk</i>	<i>3-6 times/wk</i>	<i>Every night</i>
Hallucinations (e.g. Seeing things not really there)?						
Body jerking just as you are falling asleep?						
Leg cramps which keep you from getting to sleep?						
Pain that keeps you from getting to sleep?Location:						
Thought racing or mind just won't "shut off" to allow sleep?						
Intense, irresistible, urges to move your legs?						
If "Yes" to the last question, please answer the following lettered questions. (If "No", please go on to the next question.)						
A. Are the urges worse towards the evening or at night? Yes No						
B. Are the urges worse at rest and improved by walking, rubbing, or stretching the legs? Yes No						
C. How long have you been noticing these urges? _____						
D. Do these urges occur at least twice a week? Yes No Comments: _____						
E. Are these urges bothersome enough to keep you from falling asleep rapidly? Yes No						
On weekends or days off what time do you usually go to bed (average)? _____ AM PM						
On these days what time do you usually attempt to fall asleep (average)? _____ AM PM						
How do you sleep when away from home? Worse Better Same						
Are you reported to snore at all? Yes No						

How often do you (or others) notice the following about you during sleep: (check one answer for each)	<i>Never</i>	<i>Rarely</i>	<i>1-2 times/wk</i>	<i>3-4 times/wk</i>	<i>5-7 times/wk</i>	<i>Don't Know</i>
Snorting or gasping?						
Loud snoring?						
Breathing stops, choke or struggling for breath?						
Waking suddenly with shortness of breath?						
Stopping breathing for short periods of time?						
Sweating?						
Hot flushing of your skin waking you from sleep?						
Heartburn/stomach fluids up into the throat?						
Leg cramps that wake you up out of sleep?						
Leg jerking or twitching?						
Sleep talking?						
Sleep walking?						
Nightmares?						
Physical movements/speech which mimics your dreams?						
Violent behavior during dreams, harmful to yourself or others?						
Fearful waking without remembering dreams (sleep terrors)?						
Episodes of hot flashes or flushes that wake you?						
Difficulty returning to sleep because the mind is too active?						
Waking due to pain? Where? _____						
Waking due to numbness or tingling? Where? _____						

How many times do you wake at night (average)? _____

What usually causes these awakenings? _____

How long are you usually awake each time (average) ? _____ Min _____ Hours

In what part of the night do you most frequently awaken? Early part Middle part Late part All throughout

What time do you usually get up out of bed after sleeping (average)? _____ AM PM

How much sleep would you estimate that you usually get at night (average)? _____ Hours _____ Minutes

Do you have difficulty wakening in the morning? Yes No If so, for how long? _____ Hours _____ Minutes

How often do you notice the following when wakening after your sleep:	<i>Never</i>	<i>Not in past month</i>	<i>Less than once/week</i>	<i>1-2 times/wk</i>	<i>3-6 times/wk</i>	<i>Every morning</i>
Momentary complete paralysis (cannot move for seconds?)						
Hallucinations?						
Headache?						
Dry mouth?						
Sore throat?						
Nausea?						
Confusion?						
Nasal congestion?						
Difficulty breathing through your nose?						

Marital Status (circle one): Married Domestic Partner Single Roommate

Co-Sleeping Status (circle one): Routine Occasional Sleep Alone

Bedroom Noise Level (circle one): Silent Somewhat Noisy Very Noisy

Bedroom Light Level (circle one): Dark Somewhat Light Very Light

How often are you bothered by the following problems during the daytime (or your major wake period)?	<i>Never</i>	<i>Not in past month</i>	<i>Less than once/wk</i>	<i>1-2 times/wk</i>	<i>3-6 times/wk</i>	<i>Every day</i>
Sleepiness ____ check if only in certain seasons						
Sleepiness that interferes with your work (or schooling)						
Sleepiness that interferes with your social life						
Sleepiness that makes driving difficult						
Daytime fatigue (low energy)						
Fatigue (low energy) that interferes with work (or school)						
Fatigue (low energy) that interferes with your social life						
Trouble concentrating or focusing						
Trouble with your short term memory						
I take naps						
Nasal congestion ____ check if only in certain seasons						
Postnasal drip or runny nose ____ Only in certain seasons						
Difficult nose breathing ____ check if only in certain seasons						

Do any of the problems just listed above get better with more sleep? Yes No Unsure

If you nap, how long do they usually last? _____ minutes. Do you generally feel refreshed afterwards? Yes No

How many CAFFEINE- containing beverages listed below do you usually consume in an average day?

COFFEE (8 oz. Cups): _____ TEA (8 oz. Cups): _____ SODA (e.g. 12 oz. Cans of Cola or Mountain Dew): _____

Do you use caffeine to combat fatigue? Yes No

Do you use caffeine to combat sleepiness? Yes No

What is your occupation? _____ Hours per day _____ Days per week _____

Do you work more than one shift (circle)? Yes No If "No" what is your work shift? _____

If Yes, what are your usual work shifts? From _____ AM PM to _____ AM PM for _____ days, then
 From _____ AM PM to _____ AM PM for _____ days, then
 From _____ AM PM to _____ AM PM for _____ days.

Do you participate in any regular exercise program? Yes No If "Yes" please describe: _____

How likely are you to doze off or fall asleep in each situation below, 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 those things recently, try to work out how they would have affected you. Use the following scale to check the most appropriate box for each situation.

SITUATION	<i>Never</i>	<i>Slight</i>	<i>Moderate</i>	<i>High</i>
Sitting and reading				
Watching TV				
Sitting, inactive in a public place				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

Do you notice any seasonal changes in your mood? Yes No Unsure

If so, what changes do you notice? _____

The questions below are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past week...

	<i>All of the time</i>	<i>Most of the Time</i>	<i>A Good Bit of the Time</i>	<i>Some of the Time</i>	<i>A Little of the Time</i>	<i>None of the Time</i>
Have you felt calm and peaceful?						
Have you felt downhearted and blue?						

Have you had any of the following problems in the PAST MONTH (please check yes or no)?

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Chest pain when you exert yourself?			Suicidal Thinking (past mo.)			Urination at night		
Flip-Flopping in the Chest			Shortness of breath			Number of times per night	#	
Rapid Fluttering in Chest			Wheezing			Impotence		
Pounding in the Neck			Joint Pains – where?			Difficulty Swallowing		
Fainting or near-fainting			Change in hair/nails			Tooth Pain		
Swelling of feet or ankles			Drier Skin			Jaw Joint Problems		
Irregular menstrual periods			Cold Intolerance			Please describe:		

Have you ever experienced sudden muscle weakness when you laugh? Yes No

If so, during your episodes of muscle weakness, can you hear? Yes No

If so, during your episodes of muscle weakness, does your speech ever become slurred? Yes No

If so, during your episodes of muscle weakness, is your head affected? Yes No

If so, during your episodes of muscle weakness, is your whole body affected? Yes No

Have you had any of the following conditions or operations (please check yes or no)?

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
HIGH BLOOD PRESSURE			THYROID PROBLEMS			PROSTATE SURGERY		
HEART ATTACK			Orthodontics/ Braces			HEAD INJURY		
HEART MURMUR			TONSILS REMOVED(T&A)			EPILEPSY OR SEIZURES		
ENLARGED HEART			HYSTERECTOMY			STROKE		
HEART SURGERY			NASAL SURGERY			DEPRESSION		
ANEMIA			EMPHYSEMA			ANXIETY		
IRON DEFICIENCY			ASTHMA			Psychiatric treatment		
Dentures: Partial?			HOLE IN EAR DRUM			Childhood sleep problems		
Full?								

PLEASE LIST ANY PAST SURGERIES OR ILLNESS NOT MENTIONED ABOVE:

Has one or more of your family members (blood relatives) been affected by one or more of the following illnesses(circle those that apply): Restless legs Narcolepsy Insomnia Sleep apnea

Has your thyroid level (blood test) been checked within the past year? (circle one) Yes No Unsure

If you did have blood thyroid tests, were they normal? (circle one) Yes No Unsure

Please list the medications that you usually take, including over-the-counter medications, vitamins, herbal preparations, and caffeine pills such as No Doz. You may attach a list if this is easier for you.

Medication	Dose	Times/Day	Medication	Dose	Times/Day

Have any of your medications caused or worsened your fatigue or sleepiness or insomnia? Yes No
If so which ones?

Please list any other medications not listed above (include street drugs such as cocaine and marijuana):

Please check all that apply:

Alcohol:

___ Never ___ Less than 1 drink/day ___ 1-2 drinks/day ___ More than 2 drinks/day

___ Alcohol Problem ___ Recovering Alcoholic, years of sobriety: _____

Tobacco:

___ Never ___ Still smoking ___ Quit Smoking Circle those that apply: Pipe Cigars Chew

Years of Smoking: _____ Packs per day: _____ Years since quitting: _____

Please list all previous REACTIONS or ALLERGIES to medications if any:

Medication	Reaction/Allergy	Medication	Reaction/Allergy

What is your current height? _____ Feet _____ Inches

What is your current weight? _____ Pounds

What was your weight one year ago? _____ Pounds

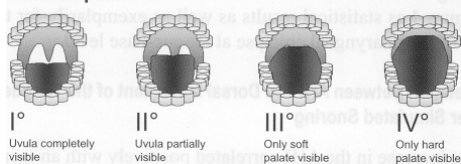
What was your weight at age 20? _____ Pounds

Any other problems you wish to discuss?

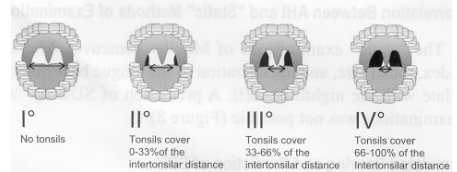
LEAVE THIS NEXT SECTION BLANK (FOR OFFICE USE ONLY)

Eyes	___ 0 exam ___ Full EOM ___ Pupils ERRLA	Neck	___ Normal Circumference: _____ cm
Ears	___ 0 exam ___ Normal ___ Perforated TM	Teeth	___ Normal Class I II III
Turbينات	___ Normal ___ Other	Tongue	___ Normal ___ High ___ Other
Septum	___ Normal ___ Dev. R L	H Palate	___ Normal ___ High ___ Torus palatinus
Columella	___ Normal ___ Dev. R L	S Palate	___ Normal ___ Low ___ Asym ___ Truncated
Lungs	___ Normal ___ Other	Uvula	___ Normal ___ Long ___ Absent ___ Edema
Abdomen	___ Normal ___ Other	Tonsils	___ 0 Seen ___ Vestigial ___ Enlarged R L
Heart	___ Normal ___ Other	Pharynx	___ Normal ___ Narrowed: AP Lat
Cranial Nerves	___ 0 exam ___ II - XII Screened and intact	Physiogn	___ Normal ___ Recessed chin ___ Long face
DT Reflexes	Right: Knee /4 Ankle /4 Left: Knee /4 Ankle /4	Extremities	___ No CCE ___ Edema: R L - A PT - Tr 1 2 3 4 ___ Motor restlessness

Mallampati Index



Tonsil size



DIFFERENTIAL DIAGNOSIS		PLANS AND ORDERS		COUNSELLING
___ OSA	___ Idiopathic hypersomnia	___ HSR or PSG	___ MWT	___ Differential Diagnosis/diagnostic options ___ Potential health risks of 0 treatment ___ Pathophysiology ___ Treatment options including 0 treatment ___ Relationship of Dx results to symptoms ___ Driving precautions _____
___ Idiopathic Insomnia	___ Psychophys Insomnia	___ HSR	___ MSLT	
___ Restless Legs	___ Leg cramps	___ PSG	___ PSG - CPAP	
___ REM SB Disorder	___ Inadeq. Sleep hyg.	___ Split-night	___ OXIMETRY	
___ Narcolepsy	___ Insufficient sleep	___ CBT		
___ DSP Syndrome	___ Primary snoring	___ Other:		
___ Chronic rhinitis	Other:			
___ Seasonal rhinitis				