SLEEP DIAGNOSTIC QUESTIONNAIRE

The answers you provide to the following questions are *very important.* Check all statements that apply to you. Please respond carefully and completely.

Name: _____ Date: _____

DOB: _____

Height (In inches): _____ Weight: _____ Age: _____ Sex: M / F

Collar size: _____ inches Referred by: _____

Please check all that apply:

___ Depression	___ COPD	___ Nightmares
___ Anxiety	___ Emphysema	___ Deviated septum
___ Nasal Stuffiness	___ Asthma	___ Tonsillectomy
___ Nasal Allergies	___ Irritable bowels	___ Throat surgery
___ Sleep walking	___ Leg cramps	___ Brain surgery
___ Sleep talking	___ Dizziness	___ Scary hallucinations
___ Heart attack	___ High blood pressure	___ Fainting spells
___ Heart Failure	___ Stroke	___ Sensation of paralysis
___ Heart Stent	___ Pain	___ Other
___Coronary Artery Disease	___ Oxygen use	___ Diabetes: Type I or Type II
___Atrial Fibrillation	___Atrial Flutter	___Opiate / Narcotic Use

When you hear bad or good news (laughing, etc.) do you feel weakness in your muscles or sagging in the face? Y / N

Do you take naps? Y / N How long are your naps? _____min

Are your naps refreshing? Y / N

Patient Signature: _____

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Name: _____ Date: _____

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1. I was referred for this sleep test because of:
   - ( ) a. Excessive sleepiness / fatigue
   - ( ) b. Loud snoring
   - ( ) c. Pauses in breathing during sleep
   - ( ) d. Insomnia
   - ( ) e. Leg jerks during sleep
   - ( ) f. Other _____

2. My sleep problem began when I was _____ years old.

3. My life and daily activities are disrupted by:
   - ( ) a. Dozing when I should be awake
   - ( ) b. Awakening unrefreshed
   - ( ) c. Trouble maintaining attention because of sleepiness

4. My sleep problem is:
   - ( ) a. Serious
   - ( ) b. Moderate
   - ( ) c. Mild
   - ( ) d. Inconsequential

5. I had an evaluation, examination or treatment for a sleep problem on _____.
   - 5a. My diagnosis was:
     - ( ) i. Periodic limb movements disorder
     - ( ) ii. Obstructive sleep apnea syndrome
     - ( ) iii. Other _____

6. Do you currently use CPAP/BiPAP? ( ) Yes ( ) No
   a. If so, what is your current pressure? _____cm H_2O.

7. a. On work days, I usually try to fall asleep at: _____ AM / PM
   b. On work days, I usually try to wake up at : _____ AM / PM
   c. On work days, I usually get out of bed at: _____ AM / PM

8. a. On non-work days, I usually try to fall asleep at: _____ AM / PM
   b. On non-work days, I usually try to be awake at: _____ AM / PM
   c. On non-work days, I usually get out of bed at: _____ AM / PM

9. a. It takes me more than 30 minutes to fall asleep: ___ days of the week (**fill in how many**)
   b. It takes me more than 60 minutes to fall asleep: ___ days of the week (**fill in how many**)

10. Often, when I am trying to fall asleep, I:
    - ( ) a. Have racing thoughts / worries
    - ( ) b. Feel sad
    - ( ) c. Feel unable to move
    - ( ) d. See vivid dream-like images
    - ( ) e. Feel abnormal sensations (crawling, aching, twitching, etc) in my legs so that I feel that I must move them
    - ( ) f. Have pain in my:1)head 2)back 3)chest 4)belly
    - ( ) g. Sleep with someone in my room
    - ( ) h. Sleep with someone in my bed
    - ( ) i. Get up to attend my children

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11. Often, when I awaken, I:

( ) a. Feel unable to move
( ) b. See vivid dream-like images
( ) c. Suddenly feel very alert
( ) d. Feel my heart pounding
( ) e. Sweat excessively
( ) f. Attend to my children
( ) g. Am confused
( ) i. Am frightened
( ) j. Have dreams
( ) k. Have nightmares
( ) l. Have headaches
( ) m. Am nauseous
( ) n. Have a dry mouth
( ) o. Awaken more than an hour too early

12. On a typical night, I sleep _____ hours.

13. It usually takes me (fill in amount of time) _____ hours _____ minutes to fall asleep

14. During the minutes before attempting to sleep, I usually:

( ) a. Watch TV
( ) b. Listen to music
( ) c. Read
( ) d. Speak with my spouse / partner
( ) e. Plan or worry
( ) f. Eat
( ) g. Drink
( ) h. Have sex
( ) i. quarrel
( ) j. Other_____

15. During a month, my total sleep per 24 hour days varies from a minimum of _____ hours to a maximum of _____ hours.

16. During a typical night, my longest single period of remaining awake without sleeping is _____ hours _____ minutes.

17. During a typical night, I awaken (how many) _____ times.

18. After falling asleep, I am most likely to awaken:

( ) a. During the first half of the night
( ) b. During the second half of the night
( ) c. At various times
( ) d. I seldom awake during the night

19. Does anyone in your family have a sleep problem? If so, please describe:

Relationship to you	***Problem***
_____	_____
_____	_____
_____	_____

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20. On a typical day, I drink:

	During a typical day	***Within two hours of bedtime***
a. Caffeinated coffee	___ cups	___ cups
b. Caffeinated tea	___ cups	___ cups
c. Caffeinated soda	___ cups	___ cups
d. Beer	___ glasses	___ glasses
e. Wine	___ glasses	___ glasses
f. Other alcohol	___ glasses	___ glasses

21. During a typical 24-hour day, I smoke:
    ( ) a. Less than one pack of cigarettes
    ( ) b. ___ pack(s) of cigarettes
    ( ) c. ___ cigars
    ( ) d. Pipe bowls
    ( ) e. I don't smoke any tobacco products

22. How often do you use the following substances?

	Never	***Sometimes***	***Often***
a. Marijuana	( ) 1.	( ) 2.	( ) 3.
b. Narcotics (Cocaine, crack, heroin, morphine, Opium, etc)	( ) 1.	( ) 2.	( ) 3.
c. Hallucinogens (LSD, mescaline, angel dust, Mushrooms, etc)	( ) 1.	( ) 2.	( ) 3.
d. Stimulants (uppers)	( ) 1.	( ) 2.	( ) 3.
e. Depressants (downers)	( ) 1.	( ) 2.	( ) 3.

23. Please print the name and doses (in mg) of all medications you take now or have taken within the last ten days.

Please print clearly and accurately. Print the name of each medication, as shown on each label. Note dosage and frequency. A misspelling can affect your diagnosis.

Name	Dose	Purpose of medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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24. I have taken these medications to treat insomnia or to help me stay awake:

Name of medication:	( ) Yes	( ) No
_____	_____	_____
_____	_____	_____
_____	_____	_____

25. I participate in an athletic activity or other exercise:
    - ( ) a. Rarely or never
    - ( ) b. One time per week
    - ( ) c. Two times per week
    - ( ) d. Three times per week
    - ( ) e. Four times per week
    - ( ) f. Five or more times per week

26. My usual working hours are from _____ to _____ .

27. What do you think causes your sleep / wake problem?

_____

_____

_____

28. My weight has ____ increased ____ decreased recently

29. Do you currently use oxygen? ( ) Yes ( ) No
    a. If so, how many liters per minute do you use? _____lpm.

Name: _____ Date: _____

_____
SIGNATURE

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SLEEP OBSERVER QUESTIONNAIRE

Name: _____ Date:_____

DOB:_____

The following questions should be answered by your bed-partner or sleep observer.

Name of patient's sleep observer: _____
Print Name

1. I have observed the patient sleeping:
   ( )a. once or twice
   ( )b. a few times
   ( )c. often

2. I have observed the patient doing the following during sleep or awakening:

( )a. snoring lightly	( )k. sitting up in bed (while asleep)
( )b. snoring loudly	( )l. awakening complaining of pain
( )c. snorting	( )m. head rocking or banging (asleep)
( )d. choking	( )n. getting out of bed (while asleep)
( )e. pauses in breathing	( )o. biting tongue
( )f. twitching or kicking of legs (asleep)	( )p. becoming rigid and/or shaking
( )g. twitching or kicking of arms (asleep)	( )q. crying out
( )h. grinding teeth (asleep)	( )r. doing semi-purposeful activity (asleep)
( )i. walking (asleep)	( )s. talking (asleep)
( )j. bed wetting	( )t. other_____

3. Describe the sleep behavior checked above. Include a description of the activity, the time during the night when it tends to occur, how frequently it occurs, and how often it occurs over the course of days, weeks, months or years.
   _____
   _____
   _____
   _____
   _____

4. Has the patient fallen asleep during normal day or evening activities or in dangerous situations?
   ( )yes ( )no

   If yes, please describe: _____
   _____
   _____
   _____
   _____

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EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

DOB: _____

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling 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 = No chance of dozing
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 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	_____

Total Score: _____

_____
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