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Initial Questionnaire

The information you provide is extremely important in assisting the Sleep Physician in reviewing and diagnosing your sleeping problems. This information will only be used for Sleep Disorders Center use and will be kept confidential.

| Demographics | | Today's Date: | |
|---|---|------------------------|---|
| | | | |
| Last Name: | First Name: | D | ate of Birth: |
| Sex: □ Male □ Femal | е | | |
| Address: | City | : | State: Zip: |
| Home Phone: | Wo | rk Phone: | |
| Email: | | | |
| | | | |
| Physician Information | on | | |
| | • | | |
| Referring Physician | | Primary Care Phy | vsician |
| Name: | | Name: | |
| Address: | | Address: | |
| | | | |
| | | | |
| Phone: | | Phone: | |
| | | | |
| Personal | | | |
| Height: Weig | ht: | | |
| Occupation: | | | |
| *Mari | tal status, race, and education | onal background are op | tional* |
| Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Race ☐ African Ame ☐ Asian / paci ☐ Caucasian ☐ Hispanic ☐ Other | erican 🗆 | ducation Less than high school High school or GED Associate's degree Bachelor's degree Master's degree Doctorate degree |

Sleeping Problems Have you experienced or been told you do any of the following: **Snoring** Gasping /choking / repeated pauses in breathing while sleeping Unusual behaviors during sleep (walking, talking, etc) Difficulty falling asleep Difficulty staying asleep Morning headache Tired/sleepy during the day Other: In your own words describe your sleeping problems: General 1. Please describe your work schedule ☐ Day shift (9-5) □ Varies ☐ Evening shift (3-11) ☐ Unemployed / □ Night shift (11-7) retired □ None 2. How many cups of caffeinated beverages do you ☐ 3 - 5 cups drink per day? ☐ 1 - 2 cups ☐ 6 or more 3. When do you usually drink your last cup of □ Before noon ☐ Before 8pm caffeinated beverage each day? ☐ Before 4pm ☐ Within 1 hour of bedtime 4. Dou you smoke Cigarettes? ☐ Yes □ No If yes, how much per day? ____ 5. How many alcoholic beverages do you have per □ None ☐ 8 - 14 drinks week on average? ☐ 1 - 7 drinks ☐ 15 drinks or more ☐ 0 davs ☐ 3 - 4 davs 6. How many days per week do you exercise 30 minutes or more? ☐ 1 - 2 days □ 5 - 7 days **Sleep Habits Work Day Non-Work Day** 1. What time do you get into bed?

1. What time do you get into bed? 2. What time do you turn off the lights to go to sleep? 3. What time do you get out of bed to start the day? 4. How many hours do you actually spend in bed? 5. How many hours do you think you actually sleep?

Sleep Habits

| 6. | How many days per week do you nap? | □ 0 days □ 1 – 2 days | | 3 – 6 days Daily |
|------|---|--|-------|--|
| 7. | If you nap, how long is your normal nap? | hours | | minutes |
| 8. | Do you have a bed partner who can observe your sleep? | ☐ Regularly ☐ Sometimes | | Rarely Never |
| Prep | aring for Sleep | | | |
| 1. | On average, how long does it take you to fall asleep at night? | ☐ Less than 5 min☐ 5 – 30 min☐ 30 – 60 min | | 1 – 2 hrs More than 2 hours |
| 2. | If it takes more than 30 minutes to fall asleep, please indicate when this started: | □ Less than 3 months□ 3 months to 1 year□ More than 1 year | | Following a specific event that occurred |
| | | | | months/years |
| 3. | How often do you use medication or alcohol to help you fall asleep? | □ Never □ 3 – 5 times/week □ 1 – 2 times/month | | 1 – 2 times/week Every night |
| | a. If you use medication what type do you use? | | | |
| 4. | Do you have a strong urge to move your legs while sitting or lying down? If yes, please | □ Yes | | No |
| | answer the following:a. Is this sensation worse when you are sitting or lying down than when you are moving around or walking? | □ Yes | | No |
| | b. Does the sensation improve if you get up, stretch your legs or walk? | □ Yes | | No |
| | c. Is the sensation worse in the evening/night than in the morning/afternoon? | □ Yes | | No |
| | d. How often does the sensation occur? | □ 2 – 4 times per month□ 2 - 3 times per week | | 4 – 5 times per week 6 – 7 times per week |
| | e. Does this sensation interfere with your sleep? | □ Yes | | No |
| 5. | Which of the following do you notice when you try to fall asleep? a. Anxiety, worry, or disturbing thought | □ Always □ Often | □ Rar | rely □ Never |
| | b. Difficulty breathing or felling suffocated | ☐ Always ☐ Often | ☐ Rar | • |
| | c. Pain | ☐ Always ☐ Often | □ Rar | • |
| | d. See and/or hear things that do not really exist | ☐ Always ☐ Often | □ Rar | • |
| | | | | |

| Duili | ilg Siee | P | | | | | | | | | |
|-------|--|---|---------|--|----------------------------|--|-------------------------|-------|-------------------------------------|---|--|
| 1. | Has anyo | ne ever told you or h | ave you | expirienced | : | | | | | | |
| | | e? Breathing or wake asping? | | Frequently Frequently | | Occasio Occasio | | | Never Never | | Don't Knov Don't Knov |
| | c. Chok d. Grind e. Sleep screa | ing for breath? I your teeth? owalk, wake up aming, or eat? | | Frequently Frequently Frequently | ' П | Occasio Occasio Occasio | nally | | Never Never Never | | Don't Knov Don't Knov Don't Knov |
| | g. Act o h. Waki | or twitch your legs? ut your dreams? ng up to urinate? : Sweats? | | Frequently Frequently Frequently Frequently | , , | Occasio Occasio Occasio Occasio | nally nally | | Never Never Never Never | | Don't Knov Don't Knov Don't Knov Don't Knov |
| 2. | How ofter | n do you wake up e night? | | Frequently | , | Occasio | nally | | Never | | Don't Knov |
| 3. | If you wal | ke up what you? | | | | | | | | | |
| 4. | What do gare awak | you do when you e? | | | | | | | | | |
| 5. | | do you stay awake ı awaken? | | | | | | | | | |
| Awa | ke | | | | | | | | | | |
| 1. | the morni a. Tired b. Suffe | _ | · | | Always Always Always | | Often Often Often | | Rarely Rarely Rarely | | Never Never Never |
| 2. | | does your sleep problework/home functioning? | | re 🗆 | Always | | Often | | Rarely | | Never |
| 3. | | ult of sleepiness, have ced any of the followi | - | | | ident k perform ated injury | | _ | Reduction in life None of the | - | ality of |
| 4. | | ı ever been unable to me when you first aw | | or 🗆 | Yes | | | | No | | |
| 5. | | u are laughing, surpri your muscles becom | | or 🗆 | Yes | | | | No | | |

Awake

6. How likely are you to dose off or fall asleep 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.

| Choose | the most appropriate response for each situation. | High Chance of Dozing | Moderate Chance of Dozing | Slight Chance of Dozing | Would Never Dose |
|--------|---|-----------------------|---------------------------|-------------------------|---------------------|
| a. | Sitting and reading | □ 3 | □ 2 | □ 1 | □ 0 |
| b. | Watching TV | □ 3 | □ 2 | 1 | □ 0 |
| c. | As a passenger in a car for an hour without a break | □ 3 | □ 2 | □ 1 | □ 0 |
| d. | Sitting inactive in a public place (theater, meeting) | □ 3 | □ 2 | □ 1 | □ 0 |
| e. | Lying down to rest in the afternoon when | □ 3 | □ 2 | □ 1 | □ 0 |
| | circumstances permit | | | | |
| f. | In a car while stopped for a few minutes in traffic | □ 3 | □ 2 | □ 1 | □ 0 |
| g. | Sitting quietly after lunch without alcohol | □ 3 | □ 2 | □ 1 | □ 0 |
| h. | Sitting and talking to someone | □ 3 | □ 2 | □ 1 | □ 0 |
| | | | | | |

Add together all the numbers you have checked off: ______

| Н | ea | lt | h |
|---|----|----|---|
| | | | |

| 1. | Which of these disorders have you ever been diagnosed with or treated for? | _ _ _ | Obstructive Sleep Apnea Central Sleep Apnea Insomnia Narcolepsy | | Restless Leg Syndrome Periodic Limb Movement Disorder Other: |
|----|---|-------------|--|---|---|
| 2. | If you've had sleep apnea treatment what sort of treatment did you have? | | CPAP Surgery | | Dental appliance Other: |
| | a. If you have been treated with CPAP: | | | Ш | Other: |
| | What were the settings? | | | | |
| | What was the type of machine? | | | | |
| | What type of mask? | | | | |
| 3. | Have any of your family members (blood relatives) been diagnosed or treated for any of these sleep disorders? | | Obstructive Sleep Apnea Central Sleep Apnea Insomnia Narcolepsy | | Restless Leg Syndrome Periodic Limb Movement Disorder Other: |
| 4. | day nearly every day, for the past two weeks? | | Yes | | No |
| 5. | In the past two weeks, have you been less interested in most things, or less able to enjoy the things you used to enjoy most of the time? | | Yes | | No |
| 6. | Have you ever experienced, or witnessed, or had to deal with an extremely traumatic event that included actual or threatened death, or serious injury to you or someone else? | | Yes | | No |
| | a. If yes, have you re-experienced this event in a distressing way (dreams, flashbacks, etc.)? | | Yes | | No |
| 7. | Have you worried excessively or been anxious about several things over the past 6 months? | | Yes | | No |

Medications

| Name of the drug , vitamin, or herbal substance used | Dose | # of pills | Times a day | Why taken? |
|--|------|------------|----------------|------------|
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Health

| 8. | Have y | ou ever been diagnosed with | any | of the following? | |
|-----|---|---|-------|--|--|
| | Asthma Emphyse Congesti Heart va Heart dis Hyperter | /nasal congestion/sinusitis ema/COPD ive heart failure live problems sease (angina, heart attack) insion (high blood pressure) heart beat wrillation | | Diabetes Hyperthyroidism (over-active thyroid) Hypothyroidism (under-active thyroid) Arthritis Kidney disease Liver disease Schizophrenia Stroke | Migraine headaches Seizures/epilepsy Down's syndrome Depression Anxiety Panic disorder High cholesterol Brain Injury Swallowing problems |
| 9. | Do you | have any other major medica | I co | nditions? (please list) | |
| 10. | Have y | ou had any major surgeries or | · hos | spitalizations? (please list) | |
| 11. | Do you | have any allergies to medicat | tions | s or environment? | |
| 12. | Womer | n only: | | | |
| | a. | Do you have regular periods? |) | ☐ Yes | |
| | b. | Are you post-menopausal | | □ Yes | ∃ No |

Please check to make sure you have all the questions filled out.

The following page is for your bed partner or for someone that has been able to watch you while you sleep if applicable. Please have this person fill out the page; their input is very important to the diagnosis of your sleeping problem.

Bed Partner Questionnaire

| | | |
|---|------|--|
| Please describe any sleep behaviors you have observed in the time during the night when it occurs, frequency it occurs | | |
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| Has this person ever fallen asleep during normal daytime a If yes please explain: | _ | |
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