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

Last Name: ___________  First Name: _______________  Date of Birth: __________

Sex:  □ Male  □ Female

Address: ___________________________  City: ___________  State: _____  Zip: _______

Home Phone: _______________  Work Phone: _______________

Email: _______________________________

Physician Information

Referring Physician  Primary Care Physician

Name: ___________________________

Address: ___________________________

Phone: _______________

Name: ___________________________

Address: ___________________________

Phone: _______________

Personal

Height: _________  Weight: _________

Occupation: _______________________________________

*Marital status, race, and educational background are optional*

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Race</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Single</td>
<td>□ African American</td>
<td>□ Less than high school</td>
</tr>
<tr>
<td>□ Married</td>
<td>□ Asian / pacific Islander</td>
<td>□ High school or GED</td>
</tr>
<tr>
<td>□ Divorced</td>
<td>□ Caucasian</td>
<td>□ Associate’s degree</td>
</tr>
<tr>
<td>□ Widowed</td>
<td>□ Hispanic</td>
<td>□ Bachelor’s degree</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
<td>□ Master’s degree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Doctorate degree</td>
</tr>
</tbody>
</table>
Sleeping Problems

Have you experienced or been told you do any of the following:

☐ Snoring  ☐ Gasping / choking / repeated pauses in breathing while sleeping
☐ Difficulty falling asleep  ☐ Unusual behaviors during sleep (walking, talking, etc)
☐ 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 / retired
   □ Night shift (11-7)

2. How many cups of caffeinated beverages do you drink per day?
   □ None
   □ 1 - 2 cups
   □ 3 - 5 cups
   □ 6 or more

3. When do you usually drink your last cup of caffeinated beverage each day?
   □ Before noon
   □ Before 4pm
   □ Before 8pm
   □ Within 1 hour of bedtime

4. Do you smoke cigarettes?
   If yes, how much per day? ________________
   □ Yes
   □ No

5. How many alcoholic beverages do you have per week on average?
   □ None
   □ 1 - 7 drinks
   □ 8 - 14 drinks
   □ 15 drinks or more

6. How many days per week do you exercise 30 minutes or more?
   □ 0 days
   □ 1 - 2 days
   □ 3 - 4 days
   □ 5 - 7 days

Sleep Habits

<table>
<thead>
<tr>
<th>Work Day</th>
<th>Non-Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What time do you get into bed?</td>
<td></td>
</tr>
<tr>
<td>2. What time do you turn off the lights to go to sleep?</td>
<td></td>
</tr>
<tr>
<td>3. What time do you get out of bed to start the day?</td>
<td></td>
</tr>
<tr>
<td>4. How many hours do you actually spend in bed?</td>
<td></td>
</tr>
<tr>
<td>5. How many hours do you think you actually sleep?</td>
<td></td>
</tr>
</tbody>
</table>
### Sleep Habits

6. How many days per week do you nap?  
   - □ 0 days  
   - □ 1 – 2 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

### Preparing 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  
   - □ 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 answer the following:  
   - □ Yes  
   - □ No

   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  
   - □ Rarely  
   - □ Never

   b. Difficulty breathing or feeling suffocated  
   - □ Always  
   - □ Often  
   - □ Rarely  
   - □ Never

   c. Pain  
   - □ Always  
   - □ Often  
   - □ Rarely  
   - □ Never

   d. See and/or hear things that do not really exist  
   - □ Always  
   - □ Often  
   - □ Rarely  
   - □ Never
## During Sleep

1. Has anyone ever told you or have you experienced:
   
   a. Snore?  
   b. Stop Breathing or wake up gasping?  
   c. Choking for breath?  
   d. Grind your teeth?  
   e. Sleepwalk, wake up screaming, or eat?  
   f. Kick or twitch your legs?  
   g. Act out your dreams?  
   h. Waking up to urinate?  
   i. Night Sweats?  

   ![Checkboxes and frequency options]

2. How often do you wake up during the night?
   
   ![Checkboxes and frequency options]

3. If you wake up what awakens you?
   
   __________________________________________________________

4. What do you do when you are awake?
   
   __________________________________________________________

5. How long do you stay awake when you awaken?
   
   __________________________________________________________

## Awake

1. How do you feel when you wake up in the morning?
   
   a. Tired  
   b. Suffer from pains or stiffness  
   c. Unpleasantly dry mouth  

   ![Checkboxes and frequency options]

2. How often does your sleep problem interfere with your work/home functioning?
   
   ![Checkboxes and frequency options]

3. As a result of sleepiness, have you experienced any of the following?
   
   ![Checkboxes and frequency options]

4. Have you ever been unable to move for a short time when you first awaken?
   
   ![Checkboxes and frequency options]

5. When you are laughing, surprised or angry do your muscles become weak or limp?
   
   ![Checkboxes and frequency options]
6. How likely are you to doze 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.

<table>
<thead>
<tr>
<th>Situation</th>
<th>High Chance of Dozing</th>
<th>Moderate Chance of Dozing</th>
<th>Slight Chance of Dozing</th>
<th>Would Never Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Watching TV</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
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<tr>
<td>Sitting inactive in a public place (theater, meeting)</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>In a car while stopped for a few minutes in traffic</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>□ 3</td>
<td>□ 2</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
</tbody>
</table>

Add together all the numbers you have checked off: _____________

### Health

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:
      - 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. Have you been consistently depressed or down, most of the 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
<table>
<thead>
<tr>
<th>Name of the drug, vitamin, or herbal substance used</th>
<th>Dose</th>
<th># of pills</th>
<th>Times a day</th>
<th>Why taken?</th>
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</table>
8. Have you ever been diagnosed with any of the following?

- □ Allergies/nasal congestion/sinusitis
- □ Asthma
- □ Emphysema/COPD
- □ Congestive heart failure
- □ Heart valve problems
- □ Heart disease (angina, heart attack)
- □ Hypertension (high blood pressure)
- □ Irregular heart beat
- □ Atrial Fibrillation
- □ 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 medical conditions? (please list)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

10. Have you had any major surgeries or hospitalizations? (please list)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

11. Do you have any allergies to medications or environment?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

12. Women only:

a. Do you have regular periods? □ Yes □ No
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

Name/Relationship of person filling out this form: _____________________________________________

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency it occurs and whether it happens every night:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ________ If yes please explain: _____________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Do you have concerns with this person's:  

Breathing at night?  ______  No
Restlessness during sleep? ______  No
Sleepwalking/talking?  ______  No
Becoming very rigid or shaking during sleep? ______  No