SLEEP DISORDER QUESTIONNAIRE

Name: ____________________________ Date of Birth: __________
Sex: M F Referring Physician: __________
Height: ______________ Weight: __________
Marital Status: __________ Current Occupation: __________

1. What is your primary sleep complaint? ______________________________________
2. How long have you had sleep problems? ______________________
3. Do you have any other problems with your sleep? ______________________
4. Have you ever been diagnosed with a sleep problem in the past? YES NO
   If yes, what was the problem? ______________________________________
5. Was sleep study (PSG) done before YES NO
   What was the therapy prescribed______________ did it help? YES NO
   When and where was the study conducted? ____________________________

EXCESSIVE SLEEPINESS:

1. Do you feel sleepy during the daytime? YES NO
   If yes, do you feel that your sleepiness is a result of poor sleep quality? YES NO
2. Have you ever had an accident due to sleepiness? YES NO
3. Have you ever felt a sudden muscle weakness when you laughed, got angry or surprised, or during times of excitement? YES NO
4. Have you ever been unable to move your body as you were waking up? YES NO
5. Have you ever had any hallucinations or vivid dreams as you were falling asleep or waking up? YES NO
6. Do you snore? (please choose one) NEVER OCCASIONALLY FREQUENTLY ALWAYS

   Please rate the loudness of your snores from 1 to 10: (with 1 for none to 10 for Very Loud) ________
7. With your snoring, do you have any episodes of:
Choking               YES          NO
Episodes of Stopping Breathing            YES          NO
Awakening               YES          NO
Has your bed partner witnessed you stop breathing in your sleep      YES          NO
8. Does position effect your snoring
   If yes, what position do you snore loudest in?__________________________
9. Do you wake up confused in the morning?        YES          NO
10. Do you wake up with a dry mouth or sore throat?  YES          NO
11. Have you experienced weight gain over the past year?             YES          NO
   If yes, approximately how much weight__________________________
12. Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)?  YES          NO
   If yes, when?_______________________________________________________________________
13. Do you have heartburn, gastric reflux, or a hiatal hernia?   YES          NO
14. Do you use oxygen or any type of medical equipment when you sleep?  YES          NO
   If yes, please describe:________________________________________________________

SLEEP SCHEDULE AND SLEEP HYGIENE

1. What time do you usually go to bed on **weekdays** or days that you work?  ____________am/pm
2. What time do you usually wake up on **weekdays** or days that you work?    ____________am/pm
   What wakes you up? _________________________________________________________________
3. What time do you usually go to bed on the **weekends** or days that you do not work? _____am/pm
4. What time do you usually wake up on the **weekends** or days that you do not work?  ______am/pm
5. Do you keep a fairly regular sleep/wake schedule?     YES          NO
6. Do you nap during the day?        YES          NO
   If so, for how many naps per day?_____
7. Are you refreshed after your nap?________
8. Circle all that apply to you: While in bed, I sometimes:   Read watch Television  Eat
   Have arguments   Worry Use Electronics
9. Do you currently work shift work or night work?  YES          NO
   If so, what hours do you work?_____am/pm to _____am/pm
   How many days per week do you work shift work? ____________________________

INSOMNIA

Answer the questions assuming “night” means your normal sleep time.
1. Do you have trouble getting to sleep at night?     YES          NO
2. What is the average amount is of minutes it takes for you to fall asleep?___Minutes
3. Do you often wake up during the night?               YES          NO
   If yes, how many times in a single night?________________________________________
4. How long does it take for you to fall back asleep?________________________________
5. How many nights a week do you have poor sleep?______________________________
6. How many hours of sleep do you get on a bad night?________________________________
7. How many hours of sleep do you get on a good night? ___________________________

8. Is your sleep disturbed by any of the following (please circle all that apply)
   - Bed Partners Habits
   - Other members of the household
   - Pets
   - Environmental factors (noise, temperature, lights)
   - Snoring
   - Breathing Difficulties
   - Trips to the bathroom
   - “mind racing”

**MOVEMENT DISORDERS**

1. Are your bed covers extremely messy when you wake up in the morning?  YES  NO
2. Do you wake yourself by kicking your legs during the night?  YES  NO
3. Has your bed partner ever complained of your leg kicking during the night?  YES  NO
4. Do you have a restless sense of discomfort in your legs before going to sleep?  YES  NO
5. Do you exercise regularly?  YES  NO

**PARASOMNIAS**

1. Do you currently have nightmares?  YES  NO
   If yes, how often? ___________________________________________________________
   If yes, at what age did they begin? ____
   If yes, did anything happen in your life that may have started these nightmares?  YES  NO
   Please explain ___________________________________________________________

2. Do you have episodes of waking at night feeling scared without obvious reason?  YES  NO
   If yes, how often: ___________________________________________________________
   If yes, are these episodes associated with sweating?  YES  NO
   If yes, are these episodes associated with a rapid heart rate?  YES  NO

3. Do you flail your arms, kick your legs, or make other purposeful movements while asleep that appear as if you are acting out your dreams?  YES  NO
   If so, do you recall any dreams or parts of a dream before these episodes?  YES  NO
   If so, are you confused with these episodes?  YES  NO
   Did you or your bed partner wake up with unexplained injury during sleep  YES  NO

4. Did you have a sleep problem as a child?  YES  NO
   If so, please describe: _______________________________________________________

5. Do you eat in your sleep?  YES  NO
   If so, do you remember doing this in the morning?  YES  NO

6. Do you grind or clench your teeth at night?  YES  NO

7. Have you ever wet the bed?  YES  NO
   If so, at what age were you and for how long did this last? ______________________

8. Have you ever been told that you walk in your sleep?  YES  NO
   If yes, at what age did these episodes occur? _________________________________

**PAST MEDICAL HISTORY**

1. Do you currently have or have you ever been diagnosed with:
   - High Blood Pressure  YES  NO
   - Heart Disease  YES  NO
   - Lung Disease  YES  NO
   - Stroke  YES  NO
   - Seizures  YES  NO
   - Head Trauma  YES  NO

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Kidney Disease YES NO  Meningitis YES NO
Diabetes YES NO  Pacemaker/Defibrillator YES NO
Emphysema/COPD YES NO  Depression YES NO

2. Explain any other medical history issues: ______________________________________________________

____________________________________________________________________________________________

3. Do you have any other comments regarding your sleep? YES NO
   If yes, please explain:  ______________________________________________________________________

____________________________________________________________________________________________

4. Is there family history of sleep problems? YES NO
   If yes, please specify ________________________________________________________________

SOCIAL HISTORY

1. Have you ever smoked? YES NO
2. Do you currently smoke? YES NO
   If yes, please give an estimate of the average number of packs per day: ___________________
3. Do you currently smoke marijuana or take any other mood-altering illicit drugs? YES NO
   If yes, please state what and how often: _____________________________________________
4. Do you currently drink alcohol? YES NO
   If yes, how many drinks do you have per night? _______  Per week? _________________________
5. Do you drink caffeinated beverages? YES NO
   If yes, How many? _______________ what time is your last caffeinated drink? _______________
EPWORTH SLEEPINESS SCALE

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 estimate how they would have affected you during the last two weeks. Use the following scale to choose the most appropriate number for each situation:

Use the following scale to choose the most appropriate number for each situation:

Scale:
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (i.e.- in a theater or a meeting)</td>
<td></td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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</tbody>
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TOTAL SCORE: __________________________________________________________