The Sleep Disorders Center at UFHealth Jacksonville
UNIVERSITY OF FLORIDA HEALTH

Downtown Campus
580 West 8th Street Tower 1
Clinics: Neurology, 9th Floor
Sleep Lab: 4th Floor
Phone: 904 244 9415
Fax: 904 244 9616

North Campus
15255 Max Leggett Pkwy
Clinics: Neurology Suite 6500
Sleep Lab: Suite 5600
Phone: 904 383 1000
Fax: 904 383 1381

Emerson Clinic
4555 Emerson Street
Suite 100
Phone: 904 383 1010
Fax: 904 383 1458

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 YES NO
   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 **weekday**s 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? YES NO
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 of 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	Stroke	YES	NO
Heart Disease	YES	NO	Seizures	YES	NO
Lung Disease	YES	NO	Head Trauma	YES	NO

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

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e.- in a theater or a 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: _____