THE CENTER FOR SLEEP MEDICINE

SLEEP SYMPTOM AND MEDICAL QUESTIONNAIRE

IDENTIFYING INFORMATION

First and Last Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Gender: _____ Marital Status: _____ Weight: _____ lbs. Height: _____ ft./in.

PRESENTING PROBLEM

Please describe your main complaint by checking one or more of the items below and providing a brief explanation of how you experience these difficulties:

1. ☐ I have trouble falling asleep
   ☐ I'm sleepy all day
   ☐ I have unwanted behaviors when I'm asleep

2. Explain: _____

_____

SLEEP SCHEDULE

Please describe your *typical* sleep schedule:

1. During the *work week*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
2. On *days off/weekends*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
3. When do you usually feel at your best? ☐ Morning ☐ Evening
4. How long does it usually take you to fall asleep? _____ (Indicate minutes or hours)
5. How many times do you wake up during the night? _____
6. How long are you usually awake when waking at night? _____ (Indicate minutes or hours)

HEALTH HABITS AFFECTING SLEEP

	Never	Little	Weekly	2-3 times/wk	Daily
1. How often do you *usually* nap?	☐	☐	☐	☐	☐
2. How often do you *usually* exercise?	☐	☐	☐	☐	☐

3a. Do you smoke cigarettes *or* have you smoked in the past? ☐ Yes ☐ No

b. If Yes: How long have you smoked? _____ (Indicate years or months)

c. How much do you smoke each day? _____ (Indicate cigarettes or packs)

d. If you've quit, when did you stop? _____ (Indicate years or months)

4a. Do you drink alcohol? ☐ Yes ☐ No

b. If Yes, at what time(s), and how much? _____

5a. Do you drink anything with caffeine regularly? ☐ Yes ☐ No
(this includes: coffee, tea, soda/pop, energy drinks)

b. If Yes, what do you drink and at what time(s) during the day or night? _____

_____

SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your sleep difficulties. Check all statements that apply:

1. ☐ I have been told that I snore loudly.
2. ☐ My bed covers are very messed up in the morning.
3. ☐ I usually toss and turn at night and am a restless sleeper.
4. ☐ I have been told that I kick and poke my bed partner during sleep.
5. ☐ My arms or legs move during sleep, sometimes waking me up.
6. ☐ I have hallucinations or dreams while falling asleep or waking up.
7. ☐ I sometimes awaken with a choking sensation.
8. ☐ I have been told that I stop breathing while asleep.
9. ☐ I have fallen out of bed.
10. ☐ I frequently wake from my sleep at night.
11. ☐ I have felt paralyzed or unable to move when waking up.
12. ☐ I have felt paralyzed or unable to move when falling asleep.
13. ☐ I awaken suddenly feeling fearful, anxious, tense or depressed.
14. ☐ When I awaken during the night, I frequently use the bathroom
15. ☐ I feel the quality of my sleep is unsatisfactory.
16. ☐ I have been told that my arms or legs twitch and jerk during my sleep.
17. ☐ I frequently get cramps in my legs.
18. ☐ I sometimes wake up with a headache.
19. ☐ I have trouble falling asleep at night.
20. ☐ I have trouble falling back to sleep when I wake up during the night.
21. ☐ Some nights I never get to sleep no matter how hard I try.
22. ☐ When I try to go to sleep my mind races with thoughts.
23. ☐ I often sleep better in a hotel or at a family member's home.
24. ☐ I have had accidents, or near accidents because of being sleepy or falling asleep.
25. ☐ The muscles in my legs feel tense, and moving my legs and feet relieves the tension.
26. ☐ I feel pain when I try to fall asleep or pain wakes me up at night.
27. ☐ I often need to take sleep pills to fall asleep.
28. ☐ I have a creeping crawling feeling in my legs when I lie down or relax.
29. ☐ I am a very light sleeper, I am awakened easily.
30. ☐ My sleep is disturbed because of my bed partner.
31. ☐ I have had occasions when I feel sudden weakness in my legs.
32. ☐ I can fall asleep at any time, regardless of the situation.
33. ☐ I feel that I sleep too much.
34. ☐ I feel that I sleep too little.
35. ☐ I generally feel sleepy all day.

SLEEPINESS

Please indicate how likely you are to fall asleep in each situation:	No chance (0)	Slight chance (1)	Moderate chance (2)	High chance (3)
1. Sitting and reading	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting inactive in a public place (e.g. theater, meeting)	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
8. In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

For each question, please CIRCLE the number that best describes your answer.
Please rate the *CURRENT* (i.e., *LAST 2 WEEKS*) *SEVERITY* of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	**0**	**1**	**2**	**3**	**4**
2. Difficulty staying asleep	**0**	**1**	**2**	**3**	**4**
3. Problem waking up too early	**0**	**1**	**2**	**3**	**4**

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not At All Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not At All Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

YOUR MEDICAL CONDITIONS

1. Please indicate if you have, or have had, any of the following conditions?

☐ Diabetes	☐ Thyroid disease	☐ Large tonsils or adenoids
☐ Arthritis	☐ Liver disease	☐ Deviated septum, crooked/broken nose
☐ Chronic pain	☐ Undergoing dialysis	☐ Dizziness or passing out
☐ Fibromyalgia	☐ Multiple sclerosis	☐ Irregular heart beat
☐ Tuberculosis	☐ Acid reflux	☐ High blood pressure
☐ Hepatitis	☐ Sinus problems	☐ Anxiety, nervousness or panic attacks
☐ Heart problems	☐ Large uvula	☐ Depression
☐ Pacemaker	☐ Morning headaches	☐ Menopause or perimenopause
☐ Defibrillator	☐ Chronic headaches	☐ Irritable bowel, ulcers, stomach pain
☐ Emphysema	☐ Seizures	☐ Cancer (type): _____
☐ Asthma	☐ Stroke	☐ Other: _____

2. Please describe any other medical conditions or current physical complaint: _____

3. Please list all medications that you take.

4. Have you undergone upper airway or sinus surgeries? If yes, please describe any surgeries performed on the nose, mouth, throat, neck or head: ☐ Yes ☐ No

5. Please list any allergies: _____

FAMILY HISTORY

Does anyone else in your family have sleep problems? ☐ Yes ☐ No

If yes, describe their relationship to you (e.g. mother, father, sister) and their condition:

OTHER INFORMATION

1. Please describe any other information you feel may affect your sleep, or your treatment with us:

Patient Name: _____

Pre-Study Adult Sleep Log								
For the week prior to your appointment, please complete the following sleep log **each day** as accurately as you can.								
	Sample	**Night 1**	**Night 2**	**Night 3**	**Night 4**	**Night 5**	**Night 6**	**Night 7**
Indicate date and day of the week:	**10/5 Monday**							
What time did you get into bed?	**10:30 pm**							
What time did you get up for the day?	**6:30 am**							
Approximately how many hours did you sleep last night?	**7.5 hrs**							
What was the quality of your sleep? (1-5) 1 = Very Poor; 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good	**2**							
Bed partner's assessment of your sleep:	**Loud snoring**							
How long did it take you to fall asleep?	**5 min**							
How many times did you awaken?	**5**							
Total time awake after sleep onset?	**25 min**							
List the time and duration of any naps you took during the day?	**4:30 pm. (2 hours)**							
List any over-the-counter or prescription sleep medication you took last night:	**None**							
Other information about your sleep:	**Tried not to nap, but had to**							