Please complete this questionnaire before your appointment.

Date completed: _____

Name: _____ Occupation: _____ Age: _____ Birth date: _____

Gender: M / F Height: _____ Weight: _____ Weight in High School: _____ Neck Size: _____ in.

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Race: Please select from the following:
American Indian/Alaska Native _____ Asian _____ Black or African American ____
Native Hawaiian or Other Pacific Islander _____ White _____

My main sleep complaint is : Briefly describe the problem: _____
[ ] Being sleepy all day _____
[ ] Trouble sleeping at night _____
[ ] Insomnia _____
[ ] Can't sleep when I want to _____
[ ] Unusual behavior in sleep _____
[ ] Other sleep problem _____
When did your problem begin?_____
Has it been getting worse? ___ Yes ____ No For how long? _____

Check all that apply:	**Yes**	**No**	**Please describe:**
1. I have a medical problem disturbing my sleep	[ ]	[ ]	_____
2. I work graveyard shifts (within past 3 months)	[ ]	[ ]	_____
3. I work swing shifts (within past 3 months)	[ ]	[ ]	_____
4. I work rotating shifts (within past 3 months)	[ ]	[ ]	_____
5. My sleep problem disturbs my sex life	[ ]	[ ]	_____
6. I sleep better away from home	[ ]	[ ]	_____
7. I read/watch TV before falling asleep	[ ]	[ ]	_____
8. I wake up often at night	[ ]	[ ]	soon after sleep [ ] middle of the night [ ] too early, I can't get back to sleep [ ]
9. My weekend sleep habits are different	[ ]	[ ]	stay up late [ ] get up late [ ] better [ ] worse [ ]
10.My sleep is disturbed by my environment	[ ]	[ ]	pain [ ] light [ ] noise [ ] bedmate [ ] cold [ ] warm [ ] Other [ ] _____
11.I will nap daily or almost everyday	[ ]	[ ]	How long?_____
12.I drink coffee/tea/cola	[ ]	[ ]	How much of each? ___ cups a day ___ cans a day ___ glasses a day
13. I use cigarettes alcohol	[ ]	[ ]	How much? ___ packs a day ___ drinks/day ___ drinks/week
14.I have allergies	[ ]	[ ]	To what? _____

Past medical history: Indicate all disorders you have diagnosed with or treated for.
Give dates or duration as necessary (i.e., Hypertension X, 1997)

	Yes	**No**		**Yes**	**No**	
Hypothyroid	[ ]	[ ]	Diabetes	[ ]	[ ]	Hospitalizations, surgeries, other medical problems:
Heart disease	[ ]	[ ]	Seizures	[ ]	[ ]	_____
Hypertension	[ ]	[ ]	Arthritis	[ ]	[ ]	_____
Hiatal Hernia	[ ]	[ ]	Cancer	[ ]	[ ]	_____
Heartburn	[ ]	[ ]	Tuberculosis	[ ]	[ ]	_____
Kidney disease	[ ]	[ ]	Emphysema	[ ]	[ ]	_____
Stroke	[ ]	[ ]	Meningitis	[ ]	[ ]	_____
Head Trauma	[ ]	[ ]				
Lung Disease	[ ]	[ ]	If yes, please indicate which disorder(s): COPD[ ] Asthma [ ] Cancer [ ] Other [ ] _____			
Sleep Disorder	[ ]	[ ]	If yes please indicate which disorder(s): Sleep Apnea [ ] Narcolepsy [ ] Restless Legs Syndrome [ ] Insomnia [ ] Other [ ] _____			

List all medications you use. Please include all intermittent over the counter medications:

	Name:	Amount:	How Often	Reason
Ex.	Tylenol	2 pills, 325mg each	Twice a day	Tension Headaches
1.				
2.				
3.				
4.				
5.				
6.				

In the past three months, have you experienced:

	Yes	No
Dizziness	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Morning headaches	[ ]	[ ]
Chest pain	[ ]	[ ]

On the average over the past year:

How many hours total do you spend in bed (awake & asleep) per night? _____ hours

How many hours do you sleep per night? _____ hours

How long does it take you to fall asleep? _____ hours

Are the hours you sleep on weeknights extremely variable? Yes [ ] No [ ]

How many hours do you sleep on an average weeknight? _____ hours

Are the hours you sleep on weekend nights extremely variable? Yes [ ] No [ ]

How many hours do you sleep on an average weekend night? _____ hours

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 work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze *2 = moderate chance of dozing*

1 = slight chance of dozing *3 = high chance of dozing*

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (theater, meeting, etc)	
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 lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

- Do you have a tendency to fall asleep or doze if you're inactive or bored? Yes [ ] No [ ]
- In the past 12 months, have you actually fallen asleep while driving a car? Yes [ ] No [ ]
- How many near-miss car accidents have you had due to drowsiness/sleepiness in the past 12 months? (circle a choice below)

  0 occurrences 1 occurrence 2 to 3 occurrences 4 to 5 occurrences 6 or more occurrences
- Please rate your daytime sleepiness by circling a number on the scale below (0 = never sleepy during daytime, 4 = always sleepy during daytime)

  0 1 2 3 4

  (never sleepy during daytime) (always sleepy during daytime)
- If you answered 1,2, 3 or 4 on previous question, for how long have you felt sleepy in the daytime? ____Months or ____Years
- On average in the past month, how often have you snored or been told that you snored? (circle one choice below)

  0 = never 1 = rarely (<once per week) 2 = sometimes (1-2 times per week) 3 = frequently (3-4 times per week) 4 = almost always (5-7 times per week)

- Please circle a "loudness" rating which best describes the volume of your snoring:
  Your rating: 0 1 2 3 4 5 6 7 8 9 10 (very loud and disturbing).
  Observer's Rating: 0 1 2 3 4 5 6 7 8 9 10 (very loud and disturbing).
- Please circle a rating which best indicates how often you snore during an average night: (0= do not snore, 4= snore constantly)
  0 1 2 3 4
  (do not snore at all) (snore constantly)
- Do you wake up choking or gasping? (circle one choice below)
  0 = never 1 = rarely (<once per week) 2 = sometimes (1-2 times per week) 3 = frequently (3-4 times per week) 4 = almost always (5-7 times per week)
- Approximately what percentage of your sleeping time do you spend on your back? (circle one choice below)
  0 = don't know 1 = rarely (0-25% of time) 2 = sometimes (25-50% of time) 3 = frequently (50-75 % of time) 4 = almost always (75-100% of time)
- Please circle a number below rating your memory loss in the last 1 to 2 years.
  (no memory loss) 0 1 2 3 4 5 6 7 8 9 10 (severe memory loss)
- How many alcoholic drinks do you have per week? (circle one choice below)
  0 drinks 1 to 4 drinks 5 to 9 drinks 10 to 14 drinks 15 or more drinks
- Indicate how many times you typically awaken during the night due to the following circumstances:

	Times Per Night	Nights Per Month
Choking	_____	_____
Gasping	_____	_____
Snoring	_____	_____
To Use Restroom	_____	_____
Other _____	_____	_____

- Have you been told by another person that you stop breathing in your sleep or wake up choking or gasping? (circle one choice below)
  0 = never 1 = rarely (<once per week) 2 = sometimes (1-2 times per week) 3 = frequently (3-4 times per week) 4 = almost always (5-7 times per week)
- How often do you experience memory loss? (circle one choice below)
  0 = never 1 = rarely (<once per week) 2 = sometimes (1-2 times per week) 3 = frequently (3-4 times per week) 4 = almost always (5-7 times per week)

Spouse, roommate, or family member

Check any of the following behaviors you have observed the patient doing while asleep.

	Never	Occasionally	Frequently	Nightly		Never	Occasionally	Frequently	Nightly
Light Snoring	[ ]	[ ]	[ ]	[ ]	Bed wetting	[ ]	[ ]	[ ]	[ ]
Loud Snoring	[ ]	[ ]	[ ]	[ ]	Sitting up asleep	[ ]	[ ]	[ ]	[ ]
Gasping for breath	[ ]	[ ]	[ ]	[ ]	Head rocking/banging	[ ]	[ ]	[ ]	[ ]
Snorts	[ ]	[ ]	[ ]	[ ]	Biting tongue	[ ]	[ ]	[ ]	[ ]
Pauses in breathing	[ ]	[ ]	[ ]	[ ]	Very rigid/shaking	[ ]	[ ]	[ ]	[ ]
Twitching of legs	[ ]	[ ]	[ ]	[ ]	Sleep walking	[ ]	[ ]	[ ]	[ ]
Grinding of teeth	[ ]	[ ]	[ ]	[ ]	Getting out of bed not awake	[ ]	[ ]	[ ]	[ ]
Sleep talking	[ ]	[ ]	[ ]	[ ]					

Describe any of the above in detail if necessary (i.e., how long has it been occurring).

_____
_____
_____
_____

Please rate the following statements by circling the appropriate number:

1=Never/Strongly disagree 2=Rarely/Disagree 3=Sometimes/Not Sure 4=Usually Agree 5=Always/Agree Strongly

I am told that I snore loudly and it disturbs others.	1 2 3 4 5	I have episodes of feeling paralyzed during my sleep.	1 2 3 4 5
I am told that I hold my breath//stop breathing at night.	1 2 3 4 5	I am often unable to move/paralyzed when awakening in the morning.	1 2 3 4 5
I wake up at night gasping for breath, unable to breathe.	1 2 3 4 5	When I am angry or surprised, I feel like my muscles are going limp.	1 2 3 4 5
I wake up at night coughing or wheezing.	1 2 3 4 5	I get “weak knees” when I laugh.	1 2 3 4 5
My snoring/breathing problem is much worse on my back.	1 2 3 4 5		
		I got bad grades in school because I was too sleepy.	1 2 3 4 5
My snoring/breathing pattern is much worse after drinking alcohol.	1 2 3 4 5	Now, I am very sleepy during the day and struggle to stay awake.	1 2 3 4 5
I sweat a great deal at night.	1 2 3 4 5	I have trouble concentrating at work or school.	1 2 3 4 5
I have a problem with nasal congestion when trying to sleep (allergies, infections, etc.)	1 2 3 4 5	I have vivid dreams soon after falling asleep or during naps.	1 2 3 4 5
I often have problems with sleepiness while I am driving.	1 2 3 4 5	I often wake up and have trouble going back to sleep.	1 2 3 4 5
I smoke tobacco within two hours of bedtime.	1 2 3 4 5	I often have to let someone drive because I am too sleepy.	1 2 3 4 5
		I have “sleep attacks” during the day no matter how hard I try to stay awake.	1 2 3 4 5
I have difficulty falling asleep.	1 2 3 4 5		
At bedtime, thoughts race through my mind.	1 2 3 4 5	I feel that I have insomnia.	1 2 3 4 5
At bedtime, I feel sad and depressed.	1 2 3 4 5	I lie awake for half an hour or more before I fall asleep.	1 2 3 4 5
I have been unable to sleep for several days.	1 2 3 4 5		
I am unhappy about loving relationships in my life.	1 2 3 4 5	I have heartburn at night.	1 2 3 4 5
I often have nightmares or am told I scream or sob in my sleep.	1 2 3 4 5	At night, my heart pounds, beats rapidly, or beats irregularly (palpitations).	1 2 3 4 5
		I frequently wake up with a dry mouth.	1 2 3 4 5
I am awakened by pain at night.	1 2 3 4 5	I wake up at night with an acid/sour taste in my mouth.	1 2 3 4 5
I have jaw pain in the morning.	1 2 3 4 5	I have noticed or I have been told that parts of my body jerk during sleep.	1 2 3 4 5
I am aware or have been told that I grind my teeth at night.	1 2 3 4 5	Trying to go to sleep, I experience an aching or crawling sensation in my legs.	1 2 3 4 5
I am stiff or sore when I get up from sleep.	1 2 3 4 5	I can’t keep my legs still at night, I have to move them to feel comfortable.	1 2 3 4 5

Sleep Log

Name: _____. ***Please do not fill out the whole week's data all at once. Doing so will be of less value to the physician when diagnosing your problem.*** ***Please fill out this sleep log every morning; about 30 minutes after getting up. Guess the approximate times and do not worry if your figures are not absolutely correct. We are interested in your opinion of how you slept and only you can tell us. Date it for the night you started, not the morning when you filled it out (for example: Sunday morning, October 5th when it is filled out; the day of the night is Saturday, October 4th). Thank you!***

	Example								
Please write the day of the week.	Sat								Day
Please write the date.	10/4								Date
Did you nap yesterday? If so, give the time and total length of sleep (in minutes).	3 pm 60mins								Naps
Did you take any sleep medications? Give the time, drug, & and amount on back of sheet.	No								Sleep meds
When did you turn out the lights, trying to sleep?	10 pm								Lights out
How many minutes did it take you to fall asleep?	10 min								Sleep onset
How often did you awake last night?	2								Waking
How many minutes were you awake last night? Do not count the time it took you to fall asleep initially?	15 min								Time waking
What time did you wake up this morning?	6:15 am								Woke up?
What time did you actually get out of bed this morning?	6:30 am								Out of bed
How many hours did you actually sleep last night?	8 hr								Hours of sleep
Compared with your own average over the last month, how well did you sleep? 1=much worse 2=Slightly worse 3=Typical 4=Slightly better 5=Much better	3								Sleep average
Overall, how refreshing was your sleep? 1=Not restorative at all 2=Slight restorative value 3=Restorative but not adequate 4=Relatively satisfactory 5=Very satisfactory/satisfactory	4								Sleep quality
List any servings of coffee, tea, colas, or chocolate you had yesterday. Morning: Afternoon: Night:	3 cups 2 cans None								Colas, coffee, tea
List any servings of beer, wine, alcohol you had yesterday. Morning: Afternoon: Night:	0 0 2 cans/beer								Drinks
Did you use any medications not listed in the first part of this form? If so, name and give the times you took anything on the back of this sheet.	No								Meds
Did you exercise yesterday? If so, list the times and number of minutes or hours spent and describe the activity.	Jog 6 pm 30 mins								Exercise

If the above listing of events is markedly different from usual, please comment (ie. Bedtimes, sleep length, etc.)