HAWAII PACIFIC NEUROSCIENCE

Adult Sleep Questionnaire

Date: _____/_____/_____

Name: _____

(First) (middle) (Last)

Address: _____

(Street) (City) (State) (Zip)

Date of birth: _____/_____/_____ Age: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____ - _____

Height: _____ Weight: _____ Neck Size: _____

Marital Status: _____ Spouse's Name: _____

Highest Education Level: _____ Occupation: _____

Place of Employment: _____

Emergency Contact: _____(_____)_____-_____

(Name) (Phone) Relationship

Referring Physician: _____ Phone: (_____) _____-_____

Physician's Address: _____

How did you hear about our sleep center?

- ❑ Physician
- ❑ Newspaper
- ❑ Radio
- ❑ Relative
- ❑ Magazine/ Journal
- ❑ Seminar
- ❑ Friend
- ❑ Television
- ❑ Other _____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE

1. How many nights a week do you have a sleeping problem? Circle one.

   1 2 3 4 5 6 7

2. How long have you had a sleeping problem?

   __ Weeks __ Months __ Years

3. Please estimate the severity of your problems.

   __ Mildly sever __ Moderately Severe __ Very Severe

   __ Extremely Severe __ Totally Severe

4. How do you describe your sleep problem? Mark all that apply.

   __ Difficulty falling asleep __ Wake up during the night

   __ Wake up early in the morning __ Difficulty awakening

5. Have you ever consulted with any of the following to help you with a sleep problem

   - ❏ Family Physician
   - ❏ Internist
   - ❏ Obstetrician
   - ❏ Chiropractor
   - ❏ Osteopathic Physician
   - ❏ Counselor
   - ❏ Social Worker
   - ❏ Clergymen
   - ❏ Neurologist
   - ❏ Cardiologist
   - ❏ Psychiatrist
   - ❏ Clinical Psychologist
   - ❏ Nutritionist
   - ❏ Nurse
   - ❏ Other Physician
   - ❏ Other

6. Describe your main problem(s) in your own words, including when and how it (they) began:

_____

_____

_____

_____

_____

_____

_____

_____

7. What treatment have you received for your sleep problem?

_____

_____

8. What is your personal interpretation as to why you have a sleep problem? Please explain.

_____

_____

_____

9. Do any other member of your family have a sleep problem? Please explain.

_____

_____

_____

10. On average, how long do you sleep at night? _____

11. What time do you usually go to bed on weekdays? _____

12. What time do you usually go to bed on weekends? _____

13. What time do you usually get up on weekdays? _____

14. What time do you usually get up on weekends? _____

15. How long does it take you to fall asleep? _____

16. How many times do you typically wake up at night? _____

17. If you wake up, on average, how long do you stay awake? _____

18. What do you usually do when you awaken during the night?

_____

_____

_____

19. When do you usually awaken during the night?

_____

_____

_____

20. How do you feel after an average night's sleep?

_____

_____

_____

21. Is the bedroom quiet and dark? ___ Yes ___ No

22. Do you sleep with the someone else in your bed? ___ Yes ___ No

23. Do you usually sleep with someone else in your room? ___ Yes ___ No

24. Do you provide assistance to someone during the night? ___ Yes ___ No

25. Do you sleep with pets? ___ Yes ___ No

26. Is your sleep often disturbed by heat or cold? ___ Yes ___ No

27. Is your sleep often disturbed by light? ___ Yes ___ No

28. Is your sleep often disturbed by your bed partner? ___ Yes ___ No

29. Is your sleep often disturbed when you are not in your usual bed? ___ Yes ___ No

30. Is your sleep often disturbed by noise? ___ Yes ___ No

31. Do you have a lighted clock dial in the bedroom? ___ Yes ___ No

32. Do you worry excessively while in bed? ___ Yes ___ No

33. Do you sleep better away from home than at home? ___ Yes ___ No

34. Do you usually drink coffee or tea within two hours of your bedtime? ___ Yes ___ No

35. Do you do physical exercise before bedtime? ___ Yes ___ No

36. Do you read before falling asleep? ___ Yes ___ No

37. Do you watch TV in bed before falling asleep? ___ Yes ___ No

38. Do you routinely nap in the daytime or evening during the week? ___ Yes ___ No

39. Do you routinely nap in the daytime or evening on weekends? ___ Yes ___ No

40. Do you feel refreshed after a short nap? (10-15 minutes) ___ Yes ___ No

41. Have you felt depressed? ___ Yes ___ No

42. Have you experienced a personality change? ___ Yes ___ No

43. Have you ever a psychiatrist or other type of counselor? ___ Yes ___ No

44. Is your present social life satisfactory? ___ Yes ___ No

45. Does your sleep problem require you to cut back on social activity? ___ Yes ___ No

46. Can you think of a stressful event which occurred near the time your sleep problem began? ___ Yes ___ No

47. Do you work variable or rotating shifts? ___ Yes ___ No

48. Is your present work situation satisfactory ___ Yes ___ No

49. Do you sleep better in your easy chair than in your bed? ___ Yes ___ No

50. If you snore, do you snore only on your back? ___ Yes ___ No

51. Have you stopped driving because of your sleep problem? ___ Yes ___ No

52. Has your weight been stable over the past year? ___ Yes ___ No

53. Please check the appropriate box for the following statements:

How often do you?	Never	Rarely	Sometimes	Frequently	Constantly
Awake from sleep short of breath?					
Are told that you snore loudly?					
Awake at night with heartburn, belching, or cough?					
Wake up with a headache in the morning?					
Have trouble sleeping when you have a cold?					
Fall asleep at public gatherings (movies, concerts, etc)?					
Have breathing problems at night?					
Sweet excessively at night?					
Are bother by long periods of wakefulness during the night?					
Feel refreshed after a short nap?					
Fall asleep during the day?					
Fall asleep involuntarily?					
Fall asleep while reading the newspaper					
Fall asleep while driving?					
Are you bothered by waking up too early and not being able to get back to sleep?					
Fall asleep during physical effort?					
Fall asleep while watching television?					
Fall asleep when laughing or crying?					
Fall asleep while talking to people?					
Feel weak as though you might fall when you are emotional? (Laughing, crying, or angry)					
Have difficulty with sexual functioning?					
Have trouble at school or work because of sleepiness?					
Fallen asleep on the job?					
Feel unable to move (paralyzed) when waking or falling asleep?					
Feel confused when you awaken from sleep?					
Experience vivid dreams upon awakening or falling asleep?					
Dream during daytime hours?					
Feel afraid of going to sleep?					
Have nightmares?					
Talk during sleep?					
Remember your dreams?					

How often do you?	Never	Rarely	Sometimes	Frequently	Constantly
Sleep walk- now or in the past?					
Have thoughts racing through your mind?					
Feel sad and depressed?					
Have anxiety?(worry about things)					
Have muscular tension?					
Notice parts of your body jerk?					
Strike out or make violent movements during sleep?					
Kick during the night?					
Have cramping in the legs at night?					
Experience crawling and aching feeling in your legs?					
Have morning jaw pain?					
Grind your teeth during sleep?					
Are bothered by pain during the day?					
Wake up feeling stiff in the morning?					
Wake up feeling sore or achy muscles?					
Wake up with pain in the neck, spine, or joints?					

54. What is your current weight? _____
55. What is your heaviest weight in the past? _____
56. How long were you at your heaviest weight? _____
57. Please list other health problems you have had and the doctor who treats you for them?
    (For example: Diabetes, heart problems, high blood pressure, etc.)

Condition	Duration	Treating Doctor

58. Please list any medications you take, including vitamins, over-the-counter, or non-prescription drugs:

Name	Amount	How often	Reason for taking

59. Please list any medications or foods you are allergic to:

Medication	Reaction

60. Do you smoke? ___ Yes ___ No
61. If you smoke, how many cigarettes per day? _____
62. Have you quit smoking? ___ Yes ___ No
63. Have you used marijuana or other mind-altering drugs? ___ Yes ___ No

64. On average, how much of each of the following beverages do you drink each day?

Beverage	How Much?
Regular coffee	
Decaffeinated coffee	
Tea	
Cola Drinks	
Other Soft Drinks	
Beer	
Mixed Drinks	
Wine	
Liquor	

66. Please Describe any other information pertinent to your sleep or wakefulness not previously described:

_____
_____
_____
_____
_____

Snoring and Sleep Apnea Screening Questionnaire

Reason for Sleep Study: ____ Sleepiness ____ Snoring ____ Disturbed Sleep

Snoring

---

1. How many years have you been told you snore? _____
2. Does your snoring disturb your bed partner……. ___ Yes ___ No

   Others in the next room? …… ___ Yes ___ No
3. Has your snoring become progressively worse? ……..... ___ Yes ___ No

   Over what period of time? _____
4. Do you snore every night? …….. ___ Yes ___ No
5. Have you been told you snore when sleeping (circle all that apply):

   on your back on your side on your stomach in sitting position
6. On a scale of 1 to 5 (1 being minimal and 5 being very loud), how loud is your snoring? _____
7. Which pattern of snoring best describes your snoring? _____

   a. Snoring is present almost continously
   b. Snoring is noted only occasionally and is not continuous
   c. I snore loudly then snoring and breathing stops, then I snore loudly again
8. Have you ever awakened from sleep because of your snoring?..... ___ Yes ___ No
9. Does any other family member snore? ……. ___ Yes ___ No

Excessive Daytime Sleepiness Scale

1. Do you usually feel tired during the day? ___ Yes ___ No

Epworth Sleepiness Scale

1. **How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way 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:**

Note: If you are currently using CPA/BIPAP therapy please choose the most appropriate number based on how you feel using positive pressure therapy.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
a) Sitting and reading ……..	_____
b) Watching TV ……	_____
c) Sitting, inactive in a public place (e.g. a theater or meeting) ……..	_____
d) As a passenger in a car for an hour without a break……	_____
e) Lying down to rest in the afternoon when circumstance permits…..	_____
f) Sitting and talking to someone……	_____
g) Sitting quietly after lunch without alcohol ……...	_____
h) In a car, while stopped for a few minutes in traffic …….	_____
	Total _____

2. How many naps do you take per day? _____ Length? _____

Do you feel regreshed after a nap? ___ Yes ___ No

3. Have you been in a car accident due to falling asleep at the wheel? ___ Yes ___ No ___ Almost

4. How many traffic tickets did you get because of sleepiness? _____

5. Please describe an incident when you fell asleep during the day when you were not expecting to fall asleep

_____

_____

_____

_____

Apneas and Narcolepsy

Have you ever been observed to stop breathing during sleep? ___ Yes ___ No

If yes, how often during a night? _____

1. Do you have sudden attacks of sleepiness? ___ Yes ___ No
2. Have you recently noticed increased irritability or trouble thinking? ___ Yes ___ No
3. Has daytime sleepiness affected your job performance or employment? ___ Yes ___ No
4. Do you have cataplexy? ___ Yes ___ No

    - Cataplexy is a brief (seconds to minutes) episode of muscle weakness e.g. jaw drop, arm or leg weakness, and/or paralysis. When the attack is over, the patient is completely mal. Laughter, anger, athletic activity, and excitement are the usual factors that initiate cataplexy.)

5. If you have cataplexy, please describe your symptoms

    _____

    _____

    _____

6. Do you have episodes of waking up with your whole body paralyzed? (Sleep paralysis) ___ Yes ___ No
7. Do you hear or see something in the beginning or the last part of sleep that is not real? (Hallucinations) ___ Yes ___ No

Medical History

1. Do you have difficulty breathing through the nose? ___ Yes ___ No
   If yes, when? ___ All Day ___ Only at night
2. Have you had:

    a. Tonsillectomy and/or adenoidectomy? ___ Yes ___ No
    b. Nasal or sinus surgery? ___ Yes ___ No
    c. Vocal chord surgery (polyp, nodules, etc)? ___ Yes ___ No
    d. Any neck operations? ___ Yes ___ No

3. Have you been treated for sleep apnea? ___ Yes ___ No
   Where? _____
   How?

a. Tracheostomy b. UPPP c. CPAP d. Drugs
   Did treatments improve:
    a. Sleepiness
    b. Snoring
    c. Tiredness
    d. Quality of sleep

Restless Leg Syndrome

1. Do you have restless or uncomfortable feelings in your legs? ___ Yes ___ No
2. Are these worse at night? ___ Yes ___ No
3. Are these feelings relieved by movement, even for a short period of time? ___ Yes ___ No

Review of Systems

Name: _____ Date: _____

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Sweats	Y	N
Weight Loss	Y	N
Eyes		
Blurred Vision	Y	N
Double Vision	Y	N
Loss of Vision	Y	N
Pain	Y	N
Other: _____		
Allergic/ Immunologic		
Hay Fever	Y	N
Drug Allergies	Y	N
Other: _____		
Neurological		
Tremors	Y	N
Dizzy Spells	Y	N
Numbness / Tingling	Y	N
Weakness	Y	N
Imbalance	Y	N
Headache	Y	N
Forgetfulness	Y	N
Other: _____		
Endocrine		
Excessive Thirst	Y	N
Too Hot / Too Cold	Y	N
Tired / Sluggish	Y	N
Gastrointestinal		
Abdominal Pain	Y	N
Nausea / Vomiting	Y	N
Indigestion / Heartburn	Y	N
Diarrhea	Y	N
Constipation	Y	N
Cardiovascular		
Chest pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Irregular Heartbeat	Y	N
Ankle Swelling	Y	N
Poor Circulation	Y	N
Other: _____		
Integumentary		
Skin Rash	Y	N
Bruise Easily	Y	N
Itching	Y	N
Hives	Y	N
Musculoskeletal		
Joint Pain	Y	N
Joint Swelling	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other: _____		
Ear/ Nose/ Throat		
Hearing Loss	Y	N
Ringing in Ears	Y	N
Vertigo	Y	N
Sinus/ Allergy problems	Y	N
Difficulty Swallowing	Y	N
Hoarseness	Y	N
Genitourinary		
Urine Retention	Y	N
Urinary Hesitancy	Y	N
Urinary Frequency	Y	N
Loss of Bladder Control	Y	N
Painful Urination	Y	N
Respiratory		
Wheezing	Y	N
Persistent Cough	Y	N
Shortness of Breath	Y	N
Hematologic / Lymphatic		
Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Phlebitis	Y	N
Bleeding	Y	N
Psychological		
Depression	Y	N
Insomnia	Y	N
Nervous / Anxious		

Reviewed by: _____ (MD Initials)

Date: ____/_____/_____

Please list an surgeries/operations that you have had:

Type of Surgery	Date	Place	Reason for Surgery

Comments:

_____

_____

_____

_____

_____