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SLEEP DISORDER SCREENING QUESTIONNAIRE

NAME (LAST, FIRST, MI)		SSN	
ADDRESS (STREET OR BOX NO.)			
CITY		STATE	ZIP
TELEPHONE (HOME)	TELEPHONE (WORK)	DATE OF BIRTH	AGE
		SEX (CIRCLE ONE) M F	
OCCUPATION		WORKING HOURS FROM _____ TO _____	
REFERRING PHYSICIAN			
REFERRING PHYSICIAN'S ADDRESS			

Height _____ Weight _____ Neck Size _____ Blood Pressure _____ Pulse _____

Any recent weight increase? Yes No How much _____ Over what time period _____

Any recent weight loss? Yes No How much _____ Over what time period _____

Reason for Sleep Study: Sleepiness Snoring Disturbed Sleep

SNORING:

- How many years have you been told you snore? _____
- Does your snoring disturb your bed partner? Yes No
- Has your snoring become progressively worse? Yes No Over what period of time? _____
- Have you been told you snore when sleeping? (*Circle all that apply*)
On your back On your side On your stomach In a sitting position
- On a scale of 1 to 5 (1 is minimal and 5 very loud), how loud is your snoring? _____
- Which pattern best describes your snoring? (*Circle one*)
a. Snoring is present almost continuously.
b. Snoring is noted only occasionally and is not continuous.
c. I snore loudly, then snoring and breathing stops, and then I snore loudly again.
- Have you ever awakened from sleep because you are snoring? Yes No

NAME: _____

EXCESSIVE DAYTIME SLEEPINESS: (*Epworth Sleepiness Scale*)

1. Do you usually feel tired during the day? Yes No
2. 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 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

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) | _____ |
| d. As a passenger in a car for an hour without a break | _____ |
| e. Lying down to rest in the afternoon when time permits | _____ |
| f. Sitting and talking to someone | _____ |
| g. Sitting quietly after a lunch without alcohol | _____ |
| h. In a car, while stopped for a few minutes in traffic | _____ |

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

Do you feel refreshed after a nap? Yes No

4. Do you experience drowsiness or a tendency to fall asleep while driving? Yes No

5. Have you been in a car accident due to falling asleep at the wheel? Yes No Near miss

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

APNEA:

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

2. Do you wake up with dry mouth? Yes No

3. How many times do you awake to go to the bathroom? _____

4. Have you ever awakened choking or gasping for breath? Yes No

5. Upon awakening, do you feel refreshed and rested? Yes No

NARCOLEPSY: (*Sleepiness with dreaming and spells of weakness*)

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 your employment? Yes No

4. Do you have cataplexy? Yes No

(Cataplexy is a brief (seconds or 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 normal. Laughter, anger, athletic activity, excitement are the usual factors that initiate an attack of cataplexy.)

5. Do you have episodes of arm or leg paralysis (sleep paralysis) during sleep? Yes No

6. Do you hear or see something in the beginning or last part of sleep that is not real? (hallucinations) Yes No

NAME: _____

LEG PROBLEMS: (*Restless legs and compulsive leg moving at night*)

1. Do you have leg cramps at night? Yes No
2. Have you ever been told that your arms or legs move a lot at night? Yes No
3. Do you experience "creepy crawling" and/or aching feeling in your legs which make you want to move them? Yes No
4. Do you jerk your arms or legs during sleep? Yes No

SLEEP STATUS AND HABITS:

1. What do you usually do the hour before bed? _____
2. Do you often read in bed? Yes No
3. Do you often watch TV in bed? Yes No
4. Do you eat in bed? Yes No
5. During the night, do you often look at the clock? Yes No
6. On average, how long does it take you to fall asleep at night? _____ Min. _____ Hrs.
7. Do you have difficulty falling and/or staying asleep? Yes No
8. What time do you usually go to bed during the week? _____ Week-ends? _____
9. What time do you usually wake up during the week? _____ Week-ends? _____
10. How many times do you usually awaken during the night? 0-1 2-3 more than 3
11. How many times do you usually awaken to urinate? 0-1 2-3 more than 3
12. How long does it take to return to sleep? _____
13. Upon awakening, do you feel tired rested/refreshed other?
14. How many hours do you sleep at night? _____

MEDICAL HISTORY:

1. Do you have difficulty breathing through the nose? Yes No
2. Do you wear dentures? Yes No
3. Have you had any of the following:
 - a. Tonsillectomy and/or adenoidectomy? Yes No When: _____
 - b. Nasal or sinus surgery? Yes No When: _____
 - c. Vocal cord surgery (polyp, nodules, etc.)? Yes No When: _____
 - d. Any neck operations? Yes No When: _____
4. Have you been treated for sleep apnea? Yes No
When: _____ Where: _____
How: Tracheostomy UPP CPAP Drugs
Did treatment improve: Sleepiness Snoring Tiredness Quality of sleep
5. Do you have any of the following:
 - a. High blood pressure Yes No
 - b. Heart disease Yes No
 - c. Morning headaches Yes No
 - d. Memory loss Yes No
 - e. Sexual problems Yes No
 - f. Lung disease Yes No
 - g. Thyroid disease Yes No
 - h. Allergy Yes No
 - i. Swelling of your legs Yes No
 - j. Urinary or kidney problems Yes No
 - k. Stroke Yes No
 - l. Diabetes Yes No
 - m. Epilepsy Yes No
 - n. Elevated cholesterol Yes No
 - o. Any other neurologic disorder Yes No _____
 - p. Any psychiatric disorder Yes No _____
 - q. Any other problems Yes No _____

NAME: _____

6. Medications:

Allergies to Any Medications: _____

7. General health: _____

8. Do you smoke? Yes No If yes, how many packs per day? _____ or cigarettes per day? _____

9. Do you drink alcoholic beverages? Yes No If yes, how much per day? _____

10. Does alcohol affect your sleep? Yes No

If yes, please describe: _____

11. How many caffeinated drinks do you have in a day? Coffee _____ Tea _____ Soda _____

12. Do you use prescription or non-prescription sleeping pills? Yes No

FAMILY HISTORY:

1. Anybody in your family snore? Yes No

2. Anybody in your family is very sleepy? Yes No

3. Anybody in your family diagnosed with sleep disorder? Yes No If yes, what? _____

ANY FURTHER COMMENTS REGARDING YOUR CONDITION NOT COVERED IN THIS FORM?

Can we use the medical information provided in this form for publications or teaching (*without identifying the patient*)?

Yes No

NAME: _____ AGE: _____ SEX: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement that best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. (0) I do not feel sad.
(1) I feel sad.
(2) I am sad all the time and I can't snap out of it.
(3) I am so sad or unhappy that I can't stand it.

2. (0) I am not particularly discouraged about the future.
(1) I feel discouraged about the future.
(2) I feel I have nothing to look forward to.
(3) I feel that the future is hopeless and that things cannot improve.

3. (0) I do not feel like a failure.
(1) I feel I have failed more than the average person.
(2) As I look back on my life, all I can see is a lot of failures.
(3) I feel I am a complete failure as a person.

4. (0) I get as much satisfaction out of things as I used to.
(1) I don't enjoy things the way I used to.
(2) I don't get real satisfaction out of anything anymore.
(3) I am dissatisfied or bored with everything.

5. (0) I don't feel particularly guilty.
(1) I feel guilty a good part of the time.
(2) I feel quite guilty most of the time.
(3) I feel guilty all of the time.

6. (0) I don't feel I am being punished.
(1) I feel I may be punished.
(2) I expect to be punished.
(3) I feel I am being punished.

7. (0) I don't feel disappointed in myself.
(1) I am disappointed in myself.
(2) I am disgusted in myself.
(3) I hate myself.

8. (0) I don't feel I am worse than anybody else.
(1) I am critical of myself all the time for my faults.
(2) I blame myself all the time for my faults.
(3) I blame myself for everything bad that happens.

NAME: _____

9. (0) I don't have any thoughts of killing myself.
(1) I have thoughts of killing myself, but I would not carry them out.
(2) I would like to kill myself.
(3) I would kill myself if I had a chance.
10. (0) I don't cry anymore than usual.
(1) I cry more now than I used to.
(2) I cry all the time now.
(3) I used to be able to cry, but now I can't cry even though I want to.
11. (0) I am no more irritated now than I ever am.
(1) I get annoyed or irritated more easily than I used to.
(2) I feel irritated all the time now.
(3) I don't get irritated at all by the things that used to irritate me.
12. (0) I have not lost interest in other people.
(1) I am less interested in other people than I used to be.
(2) I have lost most of my interest in other people.
(3) I have lost all of my interest in other people.
13. (0) I make decisions about as well as I ever could.
(1) I put off making decisions more than I used to.
(2) I have greater difficulty in making decisions than before.
(3) I can't make decisions at all anymore.
14. (0) I don't feel I look any worse than I used to.
(1) I am worried that I am looking old or unattractive.
(2) I feel that there are permanent changes in my appearance that make me look unattractive.
(3) I believe that I look ugly.
15. (0) I can work about as well as before.
(1) It takes an extra effort to get started at doing something.
(2) I have to push myself very hard to do anything.
(3) I can't do any work at all.
16. (0) I can sleep as well as usual.
(1) I don't sleep as well as I used to.
(2) I wake up 1-2 hours earlier than usual and it is hard to go back to sleep.
(3) I wake up several hours earlier than I used to and cannot get back to sleep.
17. (0) I don't get more tired than usual.
(1) I get tired more easily than I used to.
(2) I get tired from doing almost anything.
(3) I am too tired to do anything.

NAME: _____

18. (0) My appetite is no worse than usual.
(1) My appetite is not as good as it used to be.
(2) My appetite is much worse now.
(3) I have no appetite at all anymore.

19. (0) I haven't lost much weight, if any, lately.
(1) I have lost more than 5 pounds.
(2) I have lost more than 10 pounds.
(3) I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes No

20. (0) I am no more worried about my health than usual.
(1) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
(2) I am very worried about physical problems and its hard to think of much else.
(3) I am so worried about my physical problems that I cannot think about anything else.

21. (0) I have not noticed any recent change in my interest in sex.
(1) I am less interested in sex than I used to be.
(2) I am much less interested in sex now.
(3) I have lost interest in sex completely.

TOTAL SCORE _____