

C. SLEEP PATTERN

1. Circle the days of the week you work:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

2. *ON WORKDAYS*

- a. What time do you go to bed: _____
- b. What time do you get out of bed: _____

3. *ON WEEKENDS & HOLIDAYS*

- a. What time do you go to bed: _____
- b. What time do you get out of bed: _____

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

5. How many times a night do you awaken? _____

- a. How long do the awakenings last? _____
- b. List any symptoms associated with the awakenings: _____

6. *SLEEP TIME*

- a. How many hours do you usually sleep?
(do not include hours spent in bed awake) _____
- b. How many hours does it take to make you feel rested? _____
- c. How many daytime naps do you take per week? _____

7. *SLEEP QUALITY*

- a. Do you feel unrefreshed and still sleepy upon awakening? **YES** **NO**
- b. How long does it take to fully awaken in the morning? _____

8. In the daytime, are you chronically sleepy, fatigued or tired? **YES** **NO**

9. Grade your tendency to *FALL ASLEEP* during the following situations:
(0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

- a. Sitting and reading
- b. Watching TV
- c. Sitting inactive in a public place (e.g. theater or meeting)
- d. As a passenger in a car for an hour without a break
- e. Lying down to rest in the afternoon
- f. Sitting and talking to someone
- g. Sitting quietly after lunch without alcohol
- h. In a car, while stopped for a few minutes

	0	1	2	3
a. Sitting and reading				
b. Watching TV				
c. Sitting inactive in a public place (e.g. theater or meeting)				
d. As a passenger in a car for an hour without a break				
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h. In a car, while stopped for a few minutes				

D. SLEEP AND BREATHING

- | | | |
|--|-----|----|
| 1. Do you snore? | YES | NO |
| 2. Is your snoring broken by hesitations, gasps and snorts? | YES | NO |
| 3. Are the hesitations long enough to frighten your sleep partner? | YES | NO |
| 4. Has your snoring driven your bed partner from the bedroom? | YES | NO |
| 5. Do you awaken with a dry mouth? | YES | NO |
| 6. Do you awaken with headaches? | YES | NO |

E. INSOMNIA

- | | | |
|--|-----|----|
| 1. Do you have trouble falling or staying asleep? | YES | NO |
| 2. Do you worry about being able to fall asleep on time? | YES | NO |
| 3. Do you feel sleepy prior to getting into bed? | YES | NO |
| 4. Does your mind race with thoughts when lying awake? | YES | NO |
| 5. Do daytime worries keep you awake at night? | YES | NO |
| 6. Does pain disturb your sleep? | YES | NO |
| 7. Does heat, cold, hunger or thirst disturb your sleep? | YES | NO |
| 8. Is your insomnia the primary reason your life is in disarray? | YES | NO |
| 9. Do you rely on a sleeping medication? | YES | NO |
| 10. Do you watch TV, read, or work in bed? | YES | NO |
| 11. Do you frequently travel across 2 or more time zones? | YES | NO |

F. SLEEP DISTURBANCES

- | | | |
|---|-----|----|
| 1. Do you experience unpleasant leg sensations at bedtime? | YES | NO |
| 2. Do you kick or jerk your legs and/or arms during sleep? | YES | NO |
| 3. Do you have sweats or awaken from sleep feeling flushed? | YES | NO |
| 4. Do you awaken with a bitter or acid taste? | YES | NO |
| 5. Do you frequently have nightmares or vivid dreams? | YES | NO |
| 6. Do you grind your teeth or have bitten your cheek during sleep? | YES | NO |
| 7. Have you ever walked or talked in your sleep? | YES | NO |
| 8. Have you ever been unable to move for a few moments after awakening? | YES | NO |
| 9. Have you ever seen or felt things from your dreams <i>after</i> awakening? | YES | NO |
| 10. Have you ever experienced weakness when laughing or angry? | YES | NO |
| 11. Have you ever had unusual movements or behaviors during sleep? | YES | NO |

Describe: _____

G. PERSONAL HABITS

- | | | |
|--|-----|----|
| 1. Do you use tobacco now or have you in the <i>past</i> ? | YES | NO |
| a. If yes, how many per day and for how many years? _____ | | |
| b. If yes, what time of day is your last use? _____ | | |
| 2. Do you drink alcohol? | YES | NO |
| a. If yes, how many drinks? _____ per day / per week / per month (circle one). | | |
| b. If yes, what time of day is your last drink? _____ | | |
| 3. How many caffeinated beverages do you drink per day? _____ | | |
| a. If yes, what time of day is your last drink? _____ | | |

H. FAMILY HISTORY

	<u>AGE</u>	<u>MEDICAL CONDITIONS</u>
Father:	_____	_____
Mother:	_____	_____
Sibling 1:	_____	_____
Sibling 2:	_____	_____
Sibling 3:	_____	_____

(continue below if necessary)

1. List any relatives who have sleep problems or snore?

I. PERSONAL HISTORY (Check any and all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> skipped heart beats | <input type="checkbox"/> heart failure | <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> headaches | <input type="checkbox"/> emphysema | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> nasal congestion | <input type="checkbox"/> deviated nasal septum | <input type="checkbox"/> enlarged tonsils | <input type="checkbox"/> allergies |
| <input type="checkbox"/> asthma | <input type="checkbox"/> glaucoma | <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> Bipolar disorder |

J. BED PARTNER QUESTIONNAIRE (Please have your bed partner check any and all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Light snoring | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Leg or body twitching |
| <input type="checkbox"/> Heavy snoring | <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Leg jerking |
| <input type="checkbox"/> Pauses in breathing | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> Snorting | <input type="checkbox"/> Head rocking/banging | <input type="checkbox"/> Daytime confusion |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> A shaking fit | <input type="checkbox"/> Depression/anxiety |

1. Provide additional detail regarding any of the above. Please describe the activity, the time it occurs, and how often it occurs.

K. ADDITIONAL INFORMATION
