SLEEP DISORDER QUESTIONNAIRE

1. Patient Name: ___________________________________________ Date: __________________

2. Briefly describe your sleep problem. (If you have no sleep problem, please indicate why you were referred).
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

3. At what age did this problem begin? __________ years of age.
4. How does this affect your life and daily activities?
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

5. How serious is this problem for you? (Please indicate a vertical mark on the line below to indicate you answer).
   Very serious ___________________________ __________________________ Not at all serious

6. Have you had any previous evaluations, examinations, or treatments for this sleep problem or any other problem with your sleep? Yes _____ No _____
   If yes, briefly describe the evaluation, treatment and results.
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

7. Have you used any medication (prescribed or otherwise) to help your sleep problem?
   Yes _______ No _______
   If yes, list below

<table>
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<tr>
<th>Name</th>
<th>Amount</th>
<th>Frequency</th>
<th>How long Used?</th>
<th>How Useful?</th>
<th>Physician</th>
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8. For each of the beverages listed, write in the average number you drink each day
   Natural coffee _____ cups/day
   Decaffeinated Coffee _____ cups/day
   Tea _____ cups/day
   Carbonated soft drinks _____ cups/day

9. If employed, what is your usual work schedule?
   Start _____ am/pm
   Stop _____ am/pm
   Do your work shifts change? _____ Never _____ Infrequently _____ Regularly

10. What time do you usually go to bed and get up on weekdays?
    Go to bed _____ am/pm
    Get up _____ am/pm
    What time do you usually go to bed and get up on the weekends?
    Go to bed _____ am/pm
    Get up _____ am/pm
    On the average, how long does it take you to fall asleep at night after you turn off bedroom lights? _____ minutes
    What do you ordinarily do just prior to turning out the lights and attempting to go to sleep? (e.g. read, watch T.V., bathe, etc)
    ______________________________________________________
    ______________________________________________________
    On the average, how often do you wake up during the night?
    _____ times

11. On the average how long are you actually asleep at night?
    _____ hrs _____ min
    How do you ordinarily awaken?
    Spontaneously _____ Alarm Clock _____ Other ____________________________
    How difficult is it for you to awaken and get out of bed after sleeping?
    Very Difficult _____ Difficult _____ Sometimes Difficult _____ No problem _____
    How long does it take you to be alert and functioning after sleeping?
    _____ minutes
12. Are you bothered by sleeping during the day?
   Yes _____  No _____

   Do you usually feel tired during the day?
   Yes _____  No _____
   If yes, what do you attribute this to?

   Do you feel you get too much sleep at night?
   Yes _____  No _____

   Do you feel you get too little sleep at night?
   Yes _____  No _____

   Have you been told you snore while asleep?
   Yes _____  No _____
   If yes, does the snoring disturb...
   a) a bed partner or someone in the same room?
      Yes _____  No _____
   b) someone in the next room?
      Yes _____  No _____

13. Do you find yourself falling asleep when you do not want to?
    Yes _____  No _____
    If yes, describe:
    How long does the sleep episode last?
    _____ hrs _____ mins

    Do you feel rested or refreshed after the sleep episode?
    Yes _____  No _____

    Do you nap?
    Yes _____  No _____
    If yes, how many times per day _____.
    Average length of nap _____ hrs _____ mins

14. Do you wake up too early in the morning and re then unable to return to sleep?
    Yes _____  No _____

15. Have you ever:
    a. Suddenly fallen?
       Yes _____  No _____
    b. Experienced sudden bodily weakness?
       Yes _____  No _____
    If yes, to either of above, were you aware of the things around you?
       Yes _____  No _____
Was the fall or weakness brought on by any particular even or feeling (anger, sadness, laughing)

Yes_____ No_____  
If yes, briefly describe:
____________________________________________________________________________________

16. Have you ever experienced weakness or paralysis upon:
   a. going to sleep
      Yes_____ No_____  
   b. awakening from sleep
      Yes_____ No_____  
How often does this occur?
      _____times per week

17. Have you ever experienced seeing things and/or hearing voices or noises that were not real:
   a. upon going to sleep?
      Yes_____ No_____  
   b. during the night?
      Yes_____ No_____  
   c. upon wakening from sleep?
      Yes_____ No_____  
   d. during the day?
      Yes_____ No_____  

18. Do you have difficulty breathing at night?
   Yes_____ No_____  
If yes, briefly describe:
____________________________________________________________________________________
How often? _____times a night.  When did this first occur? _____years of age  
How did you become aware of this?
____________________________________________________________________________________

19. Have you ever experienced upon lying in bed before sleep or upon awakening sleep:

restless of legs______ nervous legs ______ creeping/crawling sensation of legs______
twitching______ none______

How often does this occur?
      _____times/week  
How long does the sensation last?
      _____minutes (duration)
Does anything relieve the sensation (e.g. getting out of bed, medication, massage, etc?)

Yes______ No______

At what age did you first experience this?

______years of age

20. Has anyone ever told you that arms or legs jerk or twitch while you are apparently asleep?

Yes______ No______

If yes, how often during the night does this occur?

______times/night

How many night per week does this occur?

______nights/week

At what age did this first come to your attention?

______years of age

Does seem to awaken you from sleep?

Yes______ No______

21. Have you ever experienced doing something without being aware at the time of the action?

Yes______ No______

22. Have you ever acted out dreams?

Yes______ No______

How often does this occur?

______times/week

23. Has anyone in your family been known to have any sleep problems?

Yes______ No______

If yes, please list the type of problem (e.g. trouble going to sleep, bed wetting, etc) and the person’s relationship to you.

<table>
<thead>
<tr>
<th>TYPE OF PROBLEM</th>
<th>RELATIONSHIP</th>
<th>TREATED?</th>
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24. Do you know or do others tell you that you: (leave blank if not)

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<tr>
<th>TIMES PER WEEK</th>
<th>AGE STARTED</th>
<th>LAST OCCURRED</th>
<th>TREATMENT</th>
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<tr>
<td>Talk while apparently asleep</td>
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<td>Walk while apparently asleep</td>
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<td>Grit teeth while apparently asleep</td>
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<td>Wet the bed during sleep</td>
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<td>Wake up screaming or afraid</td>
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<td>Have disturbing dreams</td>
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<td>Have unusual movements while apparently asleep</td>
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<td>Awaken during the night with headaches</td>
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<td>(Males) Have erections while asleep</td>
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25. 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. Use the following scale to choose the most appropriate number for each situation.

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

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<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
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<tr>
<td>Sitting and reading</td>
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<td>Watching TV</td>
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<td>Sitting, inactive in a public place (e.g. a theater or meeting)</td>
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<td>As a passenger in a car for an hour without a break</td>
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<td>As a driver in a car, while stopped in traffic</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<td>Sitting and talking to someone</td>
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<td>Sitting quietly after a lunch without alcohol</td>
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<td><strong>STOP-BANG Questionnaire</strong></td>
<td><strong>Yes</strong></td>
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<td>Do you Snore loudly (louder than talking or loud enough to be heard through closed doors)?</td>
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<td>Do you often feel Tired, fatigued, or sleepy during the day?</td>
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<td>Has anyone Observed that you have stopped breathing while sleeping?</td>
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<td>Do you have or are you being treated for high blood Pressure?</td>
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<td>BMI more than 35 kg/m?</td>
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<td>Are you more than 50 years of Age?</td>
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<td>Is your Neck 17 inches or greater for men (16 inches for women)?</td>
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<td>Male Gender?</td>
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