Sleep Disorders Institute Midwest

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Patient Questionaire

Name of Patient:_______________________________________

Instructions: Please fill out this questionnaire to the best of your ability and bring it with you on the night of your study.

Circle #5 when **"always"** applies and #1 when "**never"** applies, and the numbers in between when they are not the extremes of #1 and #5.

Please call (913) 754-3275 if you have any questions.

Do you feel that you:

1. Get too little sleep at night? ………………….. . . . . …. 1 2 3 4 5
2. Get too much sleep at night? . . . . …………………... . . . . . . …. 1 2 3 4 5
3. Are you sleeping worse now than you did before? . . . . …………………... 1 2 3 4 5

How great a problem do you have:

4. With sleepiness during the day (feeling sleepy, struggling to stay awake)? ………….. 1 2 3 4 5
5. With fatigue (tiredness, exhaustion) even when you are not sleepy? ………………….1 2 3 4 5
6. Because no matter how much sleep you get, you don't wake feeling rested? …………1 2 3 4 5

	Weekdays	Weekends
7. At what time do you usually go to bed?	________	________
8. At what time do you usually get up?	________	________

9. How much does your sleep vary?. . . . . …………………... 1 2 3 4 5
10. How often do you usually awaken during the night? ____________Times
11. How many hours of sleep do you usually get during the night? ______Hours
12. Have you ever stopped driving due to excessive sleepiness?. . . . . ……………………... 1 2 3 4 5
13. Have you ever had an automobile accident due to sleepiness or falling asleep?
    ○ Yes ○ No ○ More than once
14. Have you ever had a near automobile accident because of sleepiness?……………. 1 2 3 4 5
15. Do you feel refreshed after a short (10-15 minute) nap?…………………………..…… 1 2 3 4 5
16. Do other people tell you that you snore loudly?………………………………...….... 1 2 3 4 5
17. Do you wake up with morning headaches?……………………………………..……..... 1 2 3 4 5
18. Do other people tell you that you have restless sleep?……………………………… 1 2 3 4 5
19. Have other people noticed that you have become increasingly irritable or short-tempered?.. . . . .……….……….. 1 2 3 4 5
20. When you awaken in the morning, how long does it usually take for you to begin functioning normally? ○ 0-15 min.. ○ 15-30 min., ○ over 30 min
21. Do you sweat a great deal at night?…………………………………… ……. . …. 1 2 3 4 5
22. When you are angry or laugh, do you feel weak, as though you may fall?……...… 1 2 3 4 5
23. Do you have trouble getting to sleep at night?. . . . . …………… . ……… 1 2 3 4 5
24. Are you bothered by frequent awakenings during the night?……………...……… 1 2 3 4 5

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Patient Questionsaire (pg 2)

Patient Name ___________________________________

At sleep onset, how often do you:

25. Have thoughts racing through your mind?. . . . . ……………. 1 2 3 4 5
26. Feel afraid of not being able to fall asleep?. . . . . …………... . . . . 1 2 3 4 5
27. Experience restless legs (crawling or aching feelings, and inability to keep legs still?. . . . . ……...…… 1 2 3 4 5
28. Experience any kind of pain of physical discomfort?. .. . . ….……………. . . 1 2 3 4 5
29. How long does it usually take you to fall asleep? . . . . .________________________

During the night, how often do you:

30. Wake up choking, unable to breathe?. . . . . ………………. 1 2 3 4 5
31. Wake up because of heartburn?. . . . . ………….. 1 2 3 4 5
32. Notice that your heart was pounding, beating rapidly, or irregularly?………….. 1 2 3 4 5
33. Wake up to urinate? ………………………………………………………. 1 2 3 4 5
34. Wake up due to nasal congestion? ………………………………………….... 1 2 3 4 5
35. Have you ever been told that you hold your breath in your sleep? ……………. 1 2 3 4 5
36. How often do you have unusual difficulty in waking up? ……………………… 1 2 3 4 5
37. How often do you wake up more tired than when you went to bed?…………… 1 2 3 4 5
38. If you take a nap, how long do you usually sleep?. . . . .. .____________________________
39. How often do you take a nap during the day?. . . . . .___________________________
40. Do you usually feel refreshed after a nap?. . . . . ○Yes ○No
41. How often do you experience vivid dream-like images while falling asleep Or awakening, or even while you felt you were awake? ……………… 1 2 3 4 5

Questions about your general health

42. What is your body weight: Now __________lbs., 6 months go__________lbs., when heaviest ever__________lbs.

Do you have any problems with:

43. Nasal congestion, obstruction, or discharge? ………………... ○Yes ○ No
44. Please list all current medications (including non-prescription medications)

Name	Dosage Per Day
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

45. Past Medical History (Previous illnesses)

Year of onset	Name of illness
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

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Patient Questionaire (pg 3)

Patient Name ______________________________________

46. Past Medical History

___________________________________ ________________________________
___________________________________ ________________________________
___________________________________ ________________________________

47. Previous hospital admissions (include surgical operations and psychiatric admissions)

Month/Year	Location	Reason for admission
__________________	________________	______________________________
__________________	________________	______________________________

48. Previous sleep recordings or EEG's:

Month/Year	Location	Reason for admission
_________________	________________	______________________________
_________________	________________	______________________________

How much of these fluids do you drink?

	In a 24 hr. period:	Within 2 hrs. of bed	During the night
49. Coffee?	_________cups	__________cups	________ cups
50. Tea?	_________cups	__________cups	_________cups
51. Cola drinks?	_________bottles	__________bottles	_________bottles

52. Some other drinks?____

How many alcoholic drinks do you have during a usual 24-hour period?

	Weekday	Weekend
53. Bottles (cans) of beer?	______________	_______________
54. Glasses of wine?	______________	_______________
55. Shots of liquor?	______________	_______________

Tobacco and street drugs:

56. Do/did you every smoke? Yes No Started age ______ Stopped age _____

How much tobacco do you smoke during a 24-hour period?

	The past	Now
57. Packs of cigarettes?	______________	_______________

Occupation:

58. What is your present occupation? ____
59. Do you work variable shifts?____
60. How many hours per week do you work? ____
61. What is your personal interpretation as to why you have your particular sleep/wake problems?____