

Sleep Disorders Institutes
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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. Do you fall asleep watching TV?..... | 1 2 3 4 5 | |
| 13. Do you fall asleep reading the newspaper..... | 1 2 3 4 5 | |
| 14. Do you ever get extremely sleepy during driving?..... | 1 2 3 4 5 | |
| 15. Have you ever stopped driving due to excessive sleepiness?..... | 1 2 3 4 5 | |
| 16. Have you ever had an automobile accident due to sleepiness or falling asleep? | | |
| Yes No More than once | | |
| 17. Have you ever had a near automobile accident because of sleepiness?..... | | |
| | 1 2 3 4 5 | |

18. Do you fall asleep while talking to people? 1 2 3 4 5
19. Do you get particularly sleepy when you are inactive? 1 2 3 4 5
20. Do you ever feel confused when you awaken from sleep? 1 2 3 4 5
21. Do you feel refreshed after a short (10-15 minute) nap? 1 2 3 4 5
22. Do other people tell you that you snore loudly? 1 2 3 4 5
23. Does your sleepiness appear to be worse 3-4 times per day? 1 2 3 4 5
24. Does your daytime sleepiness occur at fairly predictable intervals? . . 1 2 3 4 5
25. Do you wake up with morning headaches? 1 2 3 4 5
26. Do other people tell you that you have restless sleep? 1 2 3 4 5
27. Have other people noticed that you have become increasingly irritable or short-tempered? 1 2 3 4 5
28. Has your sexuality decreased lately? 1 2 3 4 5
29. Do you have difficulty with your sexual functions? 1 2 3 4 5
30. Do you find that your mind is not working as quickly or effectively as it used to? 1 2 3 4 5
31. 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
32. Do you sweat a great deal at night? 1 2 3 4 5
33. When you are angry or laugh, do you feel weak, as though you may fall? 1 2 3 4 5
34. Do other members of your family have sleepiness problems? 1 2 3 4 5
35. Do you have trouble getting to sleep at night? 1 2 3 4 5
36. Are you bothered by frequent awakenings during the night? 1 2 3 4 5
37. Do your ankles swell? 1 2 3 4 5

At sleep onset, how often do you:

38. Have thoughts racing through your mind? 1 2 3 4 5
39. Feel afraid of not being able to fall asleep? 1 2 3 4 5
40. Experience restless legs (crawling or aching feelings, and inability to keep legs still? 1 2 3 4 5
41. Experience any kind of pain or physical discomfort? 1 2 3 4 5
42. How long does it usually take you to fall asleep? _____

During the night, how often do you:

43. Wake up choking, unable to breathe? 1 2 3 4 5
44. Wake up because of heartburn? 1 2 3 4 5
45. Notice that your heart was pounding, beating rapidly, or irregularly? . 1 2 3 4 5
46. Wake up to urinate? 1 2 3 4 5
47. Have restless, disturbed sleep? 1 2 3 4 5
48. Wake up due to nasal congestion? 1 2 3 4 5
49. Experience asthma symptoms? 1 2 3 4 5
50. Have you ever been told that you hold your breath in your sleep? . . . 1 2 3 4 5
51. How often do you have unusual difficulty in waking up? 1 2 3 4 5

52. How often do you wake up more tired than when you went to bed? . 1 2 3 4 5
53. If you take a nap, how long do you usually sleep? _____
54. How often do you take a nap during the day? _____
55. Do you usually feel refreshed after a nap? Yes No
56. 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
57. Have you ever fallen asleep at work? 1 2 3 4 5
58. How great of a problem do you have with performance at work because
of sleepiness? 1 2 3 4 5
59. How often do you discover that you have performed a complex act such
as driving a car to the wrong destination, and not remember how you
did it? 1 2 3 4 5
60. Do you think you are excessively sleepy during the daytime? 1 2 3 4 5

Questions about your general health

61. What is your body weight: Now _____ lbs., 6 months go _____ lbs.,
2 yrs. Ago _____ lbs., when age 20 _____ lbs., when heaviest ever
_____ lbs.
62. Have you had a significant change in appetite during the past 6 months?
Yes No

Do you have any problems with:

63. Nasal congestion, obstruction, or discharge? Yes No
64. Swallowing? Yes No
65. A lump or obstruction in the throat? Yes No

Have you ever had problems with your:

66. Stomach? Yes No
67. Liver? Yes No
68. Kidneys? Yes No
69. Bowels? Yes No
70. Bladder? Yes No

Have you ever had problems with:

71. Tumors? (cancer). Yes No
72. Tonsils or adenoids? Yes No
73. Sinusitis or nasal polyps? Yes No
74. Thyroid gland? Yes No
75. Low blood sugar (hypoglycemia)? Yes No
76. Sugar in your urine (diabetes)? Yes No
77. High blood pressure? Yes No
78. Heart disease? Yes No
79. Chest? (circle: Asthma, Bronchitis, Pneumonia). Yes No
80. Have you ever had your tonsils or adenoids removed? Yes No

81. Have you ever had an operation on your nose? Yes No

How often do you get pains in your:

- 82. Neck, back, joints or muscles? 1 2 3 4 5
- 83. Heart? (angina) 1 2 3 4 5
- 84. Chest? 1 2 3 4 5
- 85. Abdomen? 1 2 3 4 5
- 86. Other? 1 2 3 4 5
- 87. Have you ever been knocked unconscious? _____
- 88. Have you ever had any head injuries? _____

How often do you:

- 89. Have swelling in your ankles? 1 2 3 4 5
- 90. Suffer from numbness, pins and needles, in you arms or legs?... 1 2 3 4 5
- 91. Have headaches during the day? 1 2 3 4 5
- 92. Suffer from dizzy spells? 1 2 3 4 5
- 93. Have episodes of loss of consciousness or fainting? 1 2 3 4 5
- 94. Have convulsions, seizures, epilepsy? 1 2 3 4 5
- 95. Have shortness of breath? 1 2 3 4 5
- 96. Hold your breath or hyperventilate? 1 2 3 4 5
- 97. Have heart flutters? 1 2 3 4 5
- 98. Have allergies to food? 1 2 3 4 5
- 99. Have allergies to medications?

List _____

100. Place a mark on the line somewhere between 0 (lowest) and 10 (highest) that indicates your general level of well-being at the present time:

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9-----10

101. How much stress do you presently have? 1 2 3 4 5

102. How long have you had your sleep problem . _____

103. Describe how you feel when you wake up in the morning? _____

104. Please list all current medications (including non-prescription medications)

Name	Dosage Per Day
_____	_____
_____	_____
_____	_____
_____	_____

105. Past Medical History (Previous illnesses)

Year of onset	Name of illness
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

106. Past Medical History (Previous injuries)

Year of Injury	Type of Injury
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

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

Month/Year	Location	Reason for admission
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

108. Previous sleep recordings or EEG's:

Month/Year	Location	Reason for admission
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

How much of these fluids do you drink?

In a 24 hr. period: Within 2 hrs. of bed

During the night

109. Coffee? _____ cups _____ cups _____ cups
110. Tea? _____ cups _____ cups _____ cups
111. Cola drinks? _____ bottles _____ bottles _____ bottles
112. Some other drinks? _____

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

	Weekday	Weekend
113. Bottles (cans) of beer?	<hr/>	<hr/>
114. Glasses of wine?	<hr/>	<hr/>
115. Shots of liquor?	<hr/>	<hr/>

- How often do you drink alcoholic beverages?
116. Within 2 hours of trying to go to sleep? 1 2 3 4 5
117. During the night? 1 2 3 4 5
118. In order to get to sleep? 1 2 3 4 5
119. To steady your nerves? 1 2 3 4 5
120. Do you consume less alcohol now than you did in the past? 1 2 3 4 5

How often have you:

121. Tried to quit... 1 2 3 4 5
122. Gotten sick from drinking alcoholic beverages? 1 2 3 4 5
123. Had blackouts associated with alcoholic beverages? 1 2 3 4 5
124. Had violent or overexcited behavior associated with drinking? 1 2 3 4 5

Tobacco and street drugs:

125. How many years have you smoked? _____ Years

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

	The past	Now
126. Packs of cigarettes?	_____	_____
127. Cigars?	_____	_____
128. Pipe (bowls)?	_____	_____

How often do you smoke tobacco?

129. Within 2 hours of sleep. 1 2 3 4 5
130. During the night. 1 2 3 4 5

How often have you used any of the following to help you go to sleep?

131. Tobacco? 1 2 3 4 5
132. Marijuana? 1 2 3 4 5
133. Narcotics? 1 2 3 4 5
134. Do you take any medications to help you with your sleep? Yes No
135. Do you take any type of medication to help you with a problem with daytime sleepiness? Yes No
136. Have you ever had a prescription for sleeping medications? Yes No

Have you ever taken:

137. Insulin? Yes No
138. Cardiac drugs? Yes No
139. Cancer chemotherapy? Yes No
140. Thyroid medication? Yes No
141. Sex hormones (testosterone, estrogen)? Yes No

142. Steroids (Cortisone, Predisone)? Yes No

Occupation:

- 162. What is your present occupation? _____
- 163. Do you work variable shifts? _____
- 164. How many hours per week do you work? _____
- 165. What is your personal interpretation as to why you have your particular sleep/wake problems? _____

We at the Sleep Disorders Institutes would like to thank you for completing our Questionnaire and allowing us to assist in your health care.