SLEEP QUESTIONNAIRE

Comprehensive Sleep Disorder Center
Robert Wood Johnson University Hospital

This questionnaire is intended to provide necessary information about your medical history and any sleep related problems that you may be experiencing. It will be used to help interpret your sleep study. Please answer all the following questions by filling in the blanks or circling the appropriate number. You may omit questions that you feel do not apply to you or that you do not wish to answer. Bring this form when you first come to the clinic or to the sleep laboratory. Your cooperation is appreciated and your confidentiality assured.

Today's Date_____

1. Name_____ 2. Birthdate _____/_____/_____
   M D Y

2a. Sex: M_____ F_____ Neck size: _____

3. Height _____ 4. Current weight _____ 4a. Weight 3 years ago_____

5. Address_____
   (City) (State) (Zip)

5a. Telephone: Home(_____)_____ Cell (_____)_____
(include area code)

6. Referring Physician_____
(full name and
address if known) _____

7. If the physician who referred you for the sleep study is not your regular family physician, and you would like your regular physician to be sent a copy of the sleep report, please provide his/her name and address.

_____

_____

8. Marital Status _____ 9. Occupation _____

10. What is your ethnic background? [This question is optional.]

(1) White
(2) Black
(3) Hispanic
(4) Asian/Pacific Islander/Oriental
(5) American Indian/Alaskan Native
(6) Other (specify) _____

11. Please describe in your own words the reason you sought or are seeking this evaluation. Please include and information regarding previous sleep studies if applicable.

_____

_____

_____

12. How often do you become sleepy during the afternoon or evening?

(1) Never or almost never
(2) Sometimes
(3) Often
(4) Always or almost always

b. How would you describe the sleepiness?

(1) Irresistible need to sleep
(2) Moderately sleepy
(3) Very mild, easy to resist
(4) Always or almost always

13. How often do you feel well rested after you first get out of bed?

(1) Never or almost never
(2) Sometimes
(3) Often
(4) Always or almost always

14. 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 of each situation. Encircle your choice.

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

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g.: theater, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

15. How often do you take naps?

(1) Rarely or never
(2) Less than once a month
(3) About one a month
(4) 1 or 2 times a week
(5) 3 to 4 times a week
(6) 5 or more times a week
(7) More than once a day

. (a) Have you ever been involved in vehicular accident? _____Yes _____No
[This question is optional]

(b) If yes, number of accidents attributable to sleepiness. _____

(c) Number in which sleepiness was not a factor. _____

(d) Did personal injury result from such accidents? _____Yes _____No

16. How long do you usually sleep during your naps?

(1) Between 10 to 30 minutes
(2) Between 30 to 60 minutes
(3) Between 1 and 2 hours
(4) More than 2 hours
(5) Does not apply to me

17. Do you ever [a] feel sleepy, or [b] fall sleep: [Please mark a or b where appropriate]

(1) While driving a vehicle
(2) During a conversation
(3) While watching television
(4) While at work
(5) At the dinner table
(6) During meetings or Lectures

18.

(a) Have you been told that you snore loudly? _____Yes _____No

(b) How long have you known you snore? _____

19. What time do you usually go to bed on workdays? _____ on days off? _____

20. What time do you usually get out of bed on workdays? _____ on days off? _____

21. How many hours of sleep do you usually get on workdays? _____ on days off? _____

22. Have you ever experienced a sense of weakness or paralysis upon

(a) Going to sleep? _____Yes _____No
(b) Waking up? _____Yes _____No
(c) How often does this occur? _____

23. Have you ever experienced vivid, dream-like scenes when not fully asleep? Such as:

(a) On going to sleep? _____Yes _____No
(b) During the night? _____Yes _____No
(c) Upon awakening from sleep _____Yes _____No
(d) During the day? _____Yes _____No

24. Do you ever feel you go into a dream immediately at the onset of sleep at night or when you nap? _____Yes _____No

25. Have you ever realized that you have done something without being aware of it at the time of the action, or not known you came to be in a certain place? _____Yes _____No

If yes, please describe briefly. _____

_____

26. How long does it usually take you to fall asleep after lights out? _____hours _____minutes

27. How many times during your usual sleep period do you wake up by yourself and then go back to sleep?

(1) Never
(2) 1 or 2 times
(3) 3 or 4 times
(4) 5 or 6 times
(5) 7 or 8 times
(6) 9 or more times

28. When you wake up during your usual sleep period, how long does it usually take you to go back to sleep?

(1) 10 minutes or less
(2) 10 to 20 minutes
(3) 20 to 30 minutes
(4) 30 minutes to an hour
(5) More than an hour
(6) Does not apply to me

29. If you have trouble falling asleep, how often does this happen?

(1) Less than once a year
(2) Less than once a month
(3) About once a month
(4) 1 or 2 times per week
(5) 3 or 4 times per week
(6) 5 or more times per week
(7) Does not apply to me

30. If you have trouble falling asleep, what keeps you awake?

(1) Thinking too much
(2) Aches and pains
(3) Too much noise
(4) List any other_____
_____
(5) Does not apply to me

31. How often do you wake up early to find you cannot go back to sleep?

(1) Never or almost never
(2) Sometimes (1 or 2 days per week)
(3) Often (3 or 4 days per week)
(4) Always or almost always or more days per week)

32. Do you have any of the following? [Please circle all that apply.]

(1) Nightmares
(2) Restless Legs
(3) Sleep Terrors
(4) Sleep Walking
(5) Leg Movements
(6) Acting Out Dreams

33. (a) Is your sleep affected by frequent leg movements? _____Yes _____No

If yes, do the leg movements arouse you from sleep? _____Yes _____No

(b) While lying in bed before sleep or on awakening, have you ever experienced a restlessness of legs, "nervous legs", or a "creeping or crawling" sensation in the legs. _____Yes _____No

If yes, how many times per week does this occur? _____

(c) Have you ever experienced sudden muscle weakness or loss of strength, particularly when laughing or showing other strong emotions? _____Yes _____No

If yes, at what age did this start to occur? _____

How often do these episodes occur? _____

34. How often do you awaken with a headache in the morning?

(1) Never or almost never
(2) Sometimes
(3) Often
(4) Always or almost always

35. Do you suffer from chronic moderate-to-sever body aches?

(1) Never or almost never
(2) Sometimes
(3) Often
(4) Always or almost always

DURING THE PAST SIX MONTH, TO WHAT EXTENT HAVE YOU BEEN BOTHERED BY:

36. Increased irritability or lack of patience.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great deal

37. A decrease in your ability to remember things.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great deal

38. Feeling sad, downhearted or blue.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great deal

39. Being less involved with family, friends or activities.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great deal

40. Trouble concentrating on everyday tasks.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great del

41. Difficulty in making decisions.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Not at all			Somewhat			A great deal

42. How would you judge the overall quality of your sleep?

(1) Excellent
(2) Good
(3) Fair
(4) Poor

43. (a) Do you ever awaken choking or gasping? _____Yes _____No

(b) Has anyone ever seen you stop breathing in your sleep? _____Yes _____No

If yes, how long do these episodes supposedly last? _____

44. Do you suffer from any of the following medical condition?

Illness or Medical Condition	Yes	No	Age When First Diagnosed
Heart Failure			
Seizures			
Stroke			
Heart Attack			
Hypertension			
Other (Please List):			

45. Are you pregnant? _____Yes _____No _____N/A

46. Are you currently taking any prescription medication? _____Yes _____No
If yes, please list.

Type	Amount	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

47. Do you take any other drugs without a doctor's prescription? _____Yes _____No

Type	Amount	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

48. Do you use tobacco products? _____Yes _____No
If yes, please specify nature and amount. _____

49. How often do you drink alcohol?

(1) Never
(2) Once or twice a year
(3) Once or twice a month
(4) Every weekend
(5) Several times a week
(6) Everyday

If you drink, what is the average amount you consume? _____

50. Is there a history in your family of:

(a) Loud snoring? _____Yes _____No

If yes, which family member(s)? _____

(b) Excessive daytime sleepiness? _____Yes _____No

If yes, which family member(s)? _____

51. On the average, how many cups of caffeinated beverages do you drink per day (including coffee, tea, soft drinks, coco or energy drinks)? _____

52. Please answer the following questions if you have had a previous sleep study?

53. When was your previous sleep study and where was it done? _____

_____

54. Were you informed of the results and what were they? _____

_____

55. Are you currently or in the past ever been treated for a sleep disorder? _____Yes _____No

If yes, was treatment:
(a) Nasal CPAP or BiPAP therapy-pressure setting if known _____

How long have you been using this therapy (months/years)? _____

(b) Surgery - Specify type of procedure performed and surgery date.

_____

(c) Other - please specify _____

56. Did your sleep related complaints improve with this treatment? _____Yes _____No