DT85498

UPSTATE
UNIVERSITY HOSPITAL

Adult
SLEEP QUESTIONNAIRE

Patient Name: ______________ MR#: ______________

Account #: ______________ DOB: ______________ Date: ______________

Welcome to the Upstate Sleep Clinic. The following questions will help us understand more about you so we can consider your lifestyle when looking at your sleep study results. Please ask your bed partner to help you answer these questions. Please answer the questions as accurately as possible related to your habits over the last 12 months. Do not leave any questions unanswered. You may add comments to any of your answers in the margin beside the question. Please write clearly.

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Address: Street: ______________ City: ______________ State: ______ Zip: ______

Home Phone Number: ______________ Cell Phone Number: ______________

Age: ______ Sex: ______ Race: ______ Marital Status: ☐Married ☐Widowed ☐ Single ☐Divorced ☐Separated

Race: ☐Caucasian (White) ☐African-American ☐Asian ☐Hispanic ☐Native American ☐Other: ______________

Occupation: ______________

Height: ______ Weight: ______ Neck Circumference: ______

Has there been any recent weight gain or loss? ☐Yes ☐No If Yes, a gain of: ______ or a loss of: ______ lbs.

Over how many months has this weight gain or loss occurred?

Healthcare Professional who referred you to us for your sleep testing. (Doctor, Physician's Assistant or Nurse Practitioner, Other):

____

Here's how to answer the questions using our number scale:

1 = Rarely or Never; 2 = Sometimes; 3 = Often; 4 = Frequently; 5 = Always If your answer to any question is "No," please check "No"

1. Your main complaint(s): ☐ Snoring ☐ My breathing stops ☐ I am sleepy ☐ I talk or walk in my sleep ☐ I can't fall asleep
   Other (please comment): ______________
2. How long have you had this problem? About ______ months; about ______ years
3. How has this problem affected your life? ______________
   ____
4. I feel that I get enough sleep at night . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
5. I feel that I get too much sleep at night . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
6. On average how many hours do you sleep during a 24 hour period? ______ hours.
7. What time do you go to bed at night? ______ : ______
8. What time do you wake in the morning? ______ : ______
9. Do you change this pattern on weekends? . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
   If you do, please specify the pattern: ______________
10. No matter how much sleep I get, I wake up feeling tired . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
11. Do you have a problem with your performance at work because you are tired? . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
12. Have you fallen asleep at work? . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
13. Have you fallen asleep while driving? . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5

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14. Do you sleep with a bed partner? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
15. I tend to fall asleep during sex? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
16. Do you have a problem with sexual function? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
17. Do you snore? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
18. Does your snoring disturb others? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
19. Do you hold your breath or gasp for air in your sleep? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
20. I have trouble breathing at night ☐No ☐1 ☐2 ☐3 ☐4 ☐5
21. My sleep is disturbed by my tossing and turning at night. ☐No ☐1 ☐2 ☐3 ☐4 ☐5
22. I sweat excessively during the night ☐No ☐1 ☐2 ☐3 ☐4 ☐5
23. I wake up in the morning with a headache ☐No ☐1 ☐2 ☐3 ☐4 ☐5
24. I have asthma attacks while sleeping ☐No ☐1 ☐2 ☐3 ☐4 ☐5
25. My legs seem to kick constantly while sleeping ☐No ☐1 ☐2 ☐3 ☐4 ☐5
26. There are times when I must fall asleep and cannot ☐No ☐1 ☐2 ☐3 ☐4 ☐5
27. I have felt muscle weakness when I have strong emotional feelings ☐No ☐1 ☐2 ☐3 ☐4 ☐5
28. I have vivid dreams right after I fall asleep ☐No ☐1 ☐2 ☐3 ☐4 ☐5
29. I am unable to move when I wake up ☐No ☐1 ☐2 ☐3 ☐4 ☐5
30. A nap does not make me feel refreshed ☐No ☐1 ☐2 ☐3 ☐4 ☐5
31. Do you purposely nap on weekdays? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
32. How often do you nap and how long do you nap for? ______________________
33. What time do you nap? ________ ☐AM ________ ☐PM
34. I have a problem falling asleep at night ☐No ☐1 ☐2 ☐3 ☐4 ☐5
35. How long does it usually take you to fall asleep? ________ minutes.
36. I require special conditions to fall asleep at night. (i.e.: music, television). ☐No ☐1 ☐2 ☐3 ☐4 ☐5
37. As I try to fall asleep, anxious thoughts race through my head ☐No ☐1 ☐2 ☐3 ☐4 ☐5
38. I awaken with anxiousness, dread or worry ☐No ☐1 ☐2 ☐3 ☐4 ☐5
39. On average, how many times do you wake up during the night? ______________________
40. About how long do you spend awake during the night? ______________________
41. Is your sleep disturbed by a medical problem? ☐Yes ☐No

    If yes, please list problem(s): ______________________
42. I awaken because of aches, pains, and headaches. ☐No ☐1 ☐2 ☐3 ☐4 ☐5
43. As a child, did you have a problem falling asleep or awakening in the morning? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
44. Do you have trouble going back to sleep if you wake up during the night?. ☐No ☐1 ☐2 ☐3 ☐4 ☐5
45. I am bothered by outside noises during the night, such as planes, trains, or barking dogs ☐No ☐1 ☐2 ☐3 ☐4 ☐5
46. I tend to fall asleep when not trying to, or in a place other than my bedroom ☐No ☐1 ☐2 ☐3 ☐4 ☐5
47. As bedtime approaches, I become more anxious ☐No ☐1 ☐2 ☐3 ☐4 ☐5
48. When I am awake at night, I will lie there until I fall back to sleep ☐No ☐1 ☐2 ☐3 ☐4 ☐5
49. Because of my poor sleep at night, I feel fatigued or "washed out" during the day ☐No ☐1 ☐2 ☐3 ☐4 ☐5
50. I have a crawling, creeping feeling in the back of my legs which keeps me from falling sleep ☐No ☐1 ☐2 ☐3 ☐4 ☐5
51. Do you now or did as a child, do some sort of body rocking or head movements during sleep? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
52. Do you now or as a child, awaken in a room other than the one you fell asleep in? ☐No ☐1 ☐2 ☐3 ☐4 ☐5
53. Are you now or have you ever been a sleepwalker? ☐No ☐1 ☐2 ☐3 ☐4 ☐5

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54. According to your bed partner, have you ever seemed to be acting out a dream while asleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
55. Do you now or did you as a child, wet the bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
56. Do you now or have you ever suffered from nightmares? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
57. According to your bed partner, have you ever woke up screaming in fear or woke up agitated? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
58. Do you now or have you ever had seizures in your sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
59. I awaken in a state of panic or distress . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
60. I talk during my sleep . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
61. I grind my teeth when I am sleeping . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
62. I feel "groggy" or "sleep drunk" when I awake in the morning . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
63. Do you work a swing shift? . . . . . ☐Yes ☐No

    If yes, what hours do you work? ____________

    If yes, does your shift rotate in a clockwise direction? . . . . . ☐Yes ☐No
64. Do you go to bed at the same time every night? . . . . . ☐Yes ☐No
65. Do you fall asleep earlier than you want to, sleep normally, and then awake in the early morning hours?

    . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
66. If you were able to sleep longer, would you feel rested? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
67. Do you sleep in several periods of small time during a 24 hour period? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
68. Do you have significant stress in your life at the present time? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
69. Do you presently feel sad or depressed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
70. Have you ever been seen by a psychologist or psychiatrist? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
71. Do you take medications to stay awake or to fall asleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
72. Do you sleep in a waterbed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
73. Do you eat 1 – 2 hours before sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
74. Do you smoke before sleeping? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
75. Do you exercise before bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
76. Do you sleep alone? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
77. Do you watch TV nightly in bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
78. Have you ever had a sleep study before? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
79. Do you sleep with your pets? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
80. Do you use recreational drugs? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5

PLEASE LIST YOUR INTAKE OF THE FOLLOWING

Coffee ________ Per ________ Liquor ________ Per ________ Tea ________ Per ________

Beer ________ Per ________ Soda ________ Per ________ Cigarettes ________ Per ________

Cigars ________ Per ________ Pipes ________ Per ________ Snuff ________ Per ________

What time was your last intake of any of the above? ____________

Which was it? ____________

Are you allergic to any medications that you are aware of? . . . . . ☐Yes ☐No

If yes, please write the medications on the line(s) below:

____

____

Do you have any other past or present medical or psychiatric problems or have you had any recent surgeries? Please write them below:

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Have any of your family members had or currently have a sleep disorder? Please note below:

PLEASE LIST YOUR MEDICATIONS, BOTH PRESCRIPTION AND OVER-THE-COUNTER

Medication :	How Much?	How Often?

THE EPWORTH SLEEPINESS SCALE

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 sleep scale to choose the most appropriate number of each situation.

0 = Would never doze off **1 = Slight chance of dozing off** **2 = Moderate chance of dozing off** **3 = High chance of dozing off**

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

THANK YOU FOR YOUR COOPERATION

Patient Signature: ______________ Print Name: ______________ Date: ______________

Signature: ______________ Print Name/Title: ______________ Date/Time: ______________