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 _____/_____/______  
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.
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________


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

   (1)  White                                   (4)  Asian/Pacific Islander/Oriental
   (2)  Black                                  (5)  American Indian/Alaskan Native
   (3)  Hispanic                               (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.

   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________

Revised 10/2014
12. How often do you become sleepy during the afternoon or evening?

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

b. How would you describe the sleepiness?

   (1) Irresistible need to sleep  (3) Very mild, easy to resist
   (2) Moderately sleepy           (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  (3) Often
   (2) Sometimes            (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

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

15. How often do you take naps?

   (1) Rarely or never                                                                 (5) 3 to 4 times a week
   (2) Less than once a month                                                       (6) 5 or more times a week
   (3) About one a month                                                            (7) More than once a day
   (4) 1 or 2 times a week
(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  (4) More than 2 hours
(2) Between 30 to 60 minutes  (5) Does not apply to me
(3) Between 1 and 2 hours

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

(1) While driving a vehicle  (4) While at work
(2) During a conversation  (5) At the dinner table
(3) While watching television  (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  (4) 5 or 6 times
(2) 1 or 2 times  (5) 7 or 8 times
(3) 3 or 4 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  (4) 30 minutes to an hour
(2) 10 to 20 minutes  (5) More than an hour
(3) 20 to 30 minutes  (6) Does not apply to me

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

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

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

(1) Thinking too much  (4) List any other ________________________________
(2) Aches and pains  (5) Does not apply to me
(3) Too much noise  (6) 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  (3) Often (3 or 4 days per week)
(2) Sometimes (1 or 2 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  (4) Sleep Walking
(2) Restless Legs  (5) Leg Movements
(3) Sleep Terrors  (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?  

__________________

Revised 10/2014
(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-severe 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) Not at all  
(2) Somewhat  
(3) A great deal

37. A decrease in your ability to remember things.

(1) Not at all  
(2) Somewhat  
(3) A great deal

38. Feeling sad, downhearted or blue.

(1) Not at all  
(2) Somewhat  
(3) A great deal

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

(1) Not at all  
(2) Somewhat  
(3) A great deal

40. Trouble concentrating on everyday tasks.

(1) Not at all  
(2) Somewhat  
(3) A great deal

41. Difficulty in making decisions.

(1) Not at all  
(2) Somewhat  
(3) A great deal
42. How would you judge the overall quality of your sleep?
   (1) Excellent   (3) Fair
   (2) Good        (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?

<table>
<thead>
<tr>
<th>Illness or Medical Condition</th>
<th>Yes</th>
<th>No</th>
<th>Age When First Diagnosed</th>
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<tbody>
<tr>
<td>Heart Failure</td>
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<td>Seizures</td>
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<td>Stroke</td>
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<td>Heart Attack</td>
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<td>Hypertension</td>
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<td>Other (Please List):</td>
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45. Are you pregnant?       _____Yes   _____No   _____N/A

46. Are you currently taking any prescription medication?   _____Yes   _____No
   If yes, please list.
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<tr>
<th>Type</th>
<th>Amount</th>
<th>How Often</th>
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47. Do you take any other drugs without a doctor’s prescription?   _____Yes   _____No
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<th>Type</th>
<th>Amount</th>
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48. Do you use tobacco products? _____Yes _____No
   If yes, please specify nature and amount.

49. How often do you drink alcohol?
   (1) Never  (4) Every weekend
   (2) Once or twice a year  (5) Several times a week
   (3) Once or twice a month  (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
   (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