Sleep Interview Questionnaire

Date: _____

1. Name: Last _____ First _____ MI: ____ Male/Female
2. Date of birth: ____/____/_____ Age: _____ Marital Status: _____
3. SSN: ____-____-____ Occupation: _____ Referring Physician: _____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

4. What is your main sleep complaint? _____
5. How long has this been a problem? _____
6. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints? _____
7. Have you had a sleep study or home screen? ____ How long ago? ____ Where? _____
8. Have you ever used nasal CPAP or BiPAP? No____ Yes ____
   If so, how long? _____ Pressure setting _____ Mask _____

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation:

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

Situation	Chance of Dozing			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3
			Total	_____

Do you fall asleep or become sleepy when:	Never	Sometimes	Often	Always
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
5. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
6. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3
7. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3

8. How would you rate your overall sleepiness?	None	Mild	Moderate	Severe

While asleep do you:	Never	Sometimes	Often	Always
9. Snore?	0	1	2	3
10. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
11. Toss and turn or have restless sleep?	0	1	2	3
12. Suddenly awaken choking or gasping for breath?	0	1	2	3
13. Awaken with heartburn or acid reflux? (acid taste in mouth)	0	1	2	3
14. Walk or talk in your sleep? (circle appropriate event)	0	1	2	3
15. Have nightmares?	0	1	2	3
16. Grind your teeth?	0	1	2	3
17. Have leg or arm jerks, twitches, or kicks?	0	1	2	3
18. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
19. Wake up with a dry mouth?	0	1	2	3
20. Wake up with headaches?	0	1	2	3
21. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
22. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
23. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
24. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
25. Do you dread getting into bed because you think you will "never" fall asleep?	0	1	2	3

Section III: Sleep Habits

26. What time do you go to bed on weekdays? _____ weekends? _____
27. How long does it take you to fall asleep? _____
28. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
29. a.) How often do you awaken at night? _____
    b.) How long do you stay awake? _____
    c.) What reason? (bathroom, etc.) _____
30. What time do you get up on weekdays? _____ weekends? _____
31. How many hours of sleep do you get in a typical night? _____
32. How do you feel in the morning?
    Very sleepy? _____ Sleepy, but wake up soon _____ Wide awake, ready to go _____
33. When do you function best?

Morning:	Best	Medium	Worst
Afternoon:	Best	Medium	Worst
Evening:	Best	Medium	Worst

Section IV: Medical History

1. Please outline your medical history: Do you have or have ever been told you have

□ High Blood Pressure	□ Elevated Cholesterol	□ Migraine or Frequent Headaches
□ Sinus Problems	□ Stroke	□ Parkinson's
□ Diabetes	□ GI Disease	□ Dementia (Alzheimer's, etc.)
□ Arthritis	□ Cancer	□ Prior History of Sleep Apnea
□ Thyroid Problems	□ Frequent Nighttime Urination	□ Prior History of Restless Legs
□ Anemia	□ Depression and/or Anxiety	□ Obesity
□ Heart Disease	□ Liver Disease	□ Abnormal Behavior During Sleep
□ Lung Disease	□ Seizures or Epilepsy	

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

2. List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name	Dosage	How often	Reason

3. Your weight? _____Your height? _____
4. Do you smoke? _____ If yes, how long? _____ How much? _____/ day
5. Do you drink alcohol? _____ If yes, how long? _____ How much? ____/ day/wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)? _____ How much? ____/ day/wk/mo

General History

1. Have you had any recent problems with your memory or concentration? _____
   If yes, explain: _____
   _____
2. Have you noticed any changes in your mood or irritability lately? _____
   If yes, explain: _____
   _____
3. Are you having any other problems (e.g. stress, anxiety, or pressures)? _____
   If yes, explain: _____
   _____
4. Have you been depressed lately? _____
   If yes, explain: _____
   _____
5. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)?__
   If yes, explain: _____
   _____
6. Do you often travel across time zones, thereby affecting your sleep/wake schedule? _____
   If yes, explain: _____
   _____
7. Do you work night shifts and/or rotating shifts? _____
   If yes, explain: _____
   _____
8. How did you hear about us? Physician referral/Friend/Web Page/Phone Book
   or advertisement in the _____