PATIENT SLEEP/WAKE QUESTIONNAIRE

Today's Date: ______________

Patient Name: ______________________________ Date of Birth: ____________ Sex: ☐ M ☐ F

Ht: ________ Wt: __________ Occupation: ____________________ Marital Status: ____________

What do you feel is your chief sleep complaint? ____

____

____

How long have you had this problem? ____

What is the effect of the sleep complaint on your life?

☐ severe ☐ considerable ☐ moderate ☐ slight ☐ none

Does your sleep problem get worse or better at various times of the month of year? ☐ Yes ☐ No

If yes, explain: ____

Is there anyone who has regularly observed your sleep? ☐ Yes ☐ No

If yes, please ask him/her to complete the Sleep Observer Questionnaire.

SLEEP HISTORY

General

What time do you usually go to bed at night? ______________________________

What time do you usually get out of bed in the morning? ______________________________

How many hours per night do you usually sleep? ______________________________

Sleep Onset

How long does it usually take you to fall asleep after you go to bed? ______________________

Have you ever had difficulty falling asleep? ☐ Yes ☐ No

When falling asleep, do you:

☐ Yes ☐ No Feel afraid of not being able to get to sleep?

☐ Yes ☐ No Feel unable to move (paralyzed)?

☐ Yes ☐ No Experience vivid, dream-like scenes even though you know you are awake?

☐ Yes ☐ No Notice that parts of your body jerk or startle?

☐ Yes ☐ No Feel muscular tension?

☐ Yes ☐ No Experience pain or physical discomfort?

☐ Yes ☐ No Experience environmental factors that keep you awake (i.e. temp, noise)?

Sleep Disturbances

Have you ever awakened during the night? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Do you provide assistance or attention to someone or something (child, other adult, or pet) during the night?

☐ Yes ☐ No If yes, how often? ______________________________

How many times during a typical night's sleep do you wake up? ______ times

How long are you typically awake? ______________________________

Does your sleep disturbance come in the ☐ first ☐ middle ☐ last third of your sleep?

How often do you get out of bed when you awaken during the night? ______________________________

How long are you typically out of bed? ______________________________

Do other people tell you that you snore? ☐ Yes ☐ No If yes, how many years have you snored? ______

How often is your sleep disturbed by: (Check one response for each question below)

	Never	Seldom	Often	Always
"Gas" in your stomach, indigestion, or heartburn?	☐	☐	☐	☐
Gasping for breath, choking, or inability to breathe?	☐	☐	☐	☐
Asthma?	☐	☐	☐	☐
Excessive sweating throughout the night?	☐	☐	☐	☐
Headaches?	☐	☐	☐	☐
Chest pain(s)?	☐	☐	☐	☐
Irregular or pounding heart beats?	☐	☐	☐	☐
Leg cramps?	☐	☐	☐	☐
Crawling or aching feeling in your legs?	☐	☐	☐	☐
Pain in your neck, back, spine, muscles, joints, or limbs?	☐	☐	☐	☐
Paresthesia ("pins & needles") in your limbs?	☐	☐	☐	☐
An urgent desire to urinate?	☐	☐	☐	☐
Bedwetting?	☐	☐	☐	☐
Frightening or recurring dreams?	☐	☐	☐	☐
Sleep walking?	☐	☐	☐	☐
Sleep talking?	☐	☐	☐	☐
Other (describe): ______________________	☐	☐	☐	☐

Awakening

On a typical morning, how long does it take you to get out of bed after you have awakened? ________________

Do you get up at the same time every day (or 5 out of 7 days per week)? ☐ Yes ☐ No

If no, explain: ______________________________

Has it been unusually difficult for you to wake up in the morning? ☐ Yes ☐ No If yes, how long? ________

Do you wake up: (Check one response for each question below)

	Never	Sometimes	Frequently	Always
With morning headaches?	☐	☐	☐	☐
With pains in your arms or legs?	☐	☐	☐	☐
Coughing up excessive amounts of material?	☐	☐	☐	☐
Feeling unable to move (paralyzed)?	☐	☐	☐	☐
Having dream-like images even though you know you are not asleep?	☐	☐	☐	☐
With pains in your jaw?	☐	☐	☐	☐
Somewhere other than where you went to sleep?	☐	☐	☐	☐
Confused, disoriented, or even violent?	☐	☐	☐	☐

DAYTIME SLEEPINESS/WAKEFULNESS

How often is daytime sleepiness a problem? ☐ Never ☐ Occasionally ☐ Often ☐ Always

What time of the day are you sleepy? ☐ Morning ☐ Afternoon ☐ Evening

How often do you feel fatigued even when you are not sleepy?
☐ Never ☐ Occasionally ☐ Often ☐ Always

Do you ever have problems with your performance at work because of daytime sleepiness?
☐ Never ☐ Occasionally ☐ Often ☐ Always

Have you ever had an accident at work because of sleepiness? ☐ Yes ☐ No
If yes, explain: ______________________________

Have you ever been told that you have narcolepsy? ☐ Yes ☐ No

Have you ever had an episode of sudden muscular weakness ("weak knees" or paralysis) when laughing, angry, or otherwise expressing emotion? ☐ Yes ☐ No
If yes, how often? ______________________________

At what time of the day do you feel most alert and energetic (i.e. morning, midday, afternoon, etc.)?
____

Do you nap during the day? ☐ Yes ☐ No If yes, how often? ______________

How long do you usually nap? ______________________________

Do you feel refreshed and alert after a brief nap? ☐ Yes ☐ No

Are you aware of any increasing difficulty in your concentration or your ability to retain information? ☐ Yes ☐ No

Have you noticed a decreasing interest in sexual activity? ☐ Yes ☐ No

Are you experiencing either chronic or new onset pain? ☐ Yes ☐ No If yes, how severe? __________

Have you ever had to stop driving because of sleepiness (i.e. arrange for an alternative to your daily form of commuting)? ☐ Yes ☐ No

Have you ever been involved in an auto accident caused by your sleepiness? ☐ Yes ☐ No

EMOTIONAL FACTORS

How much stress do you have at the present time? ☐ None ☐ Slight ☐ Moderate ☐ Considerable ☐ A lot

Have you ever seen a clinical psychologist or psychiatrist? ☐ Yes ☐ No

SOCIAL HISTORY

Have you gained or lost a lot of weight over the past year? ☐ Yes ☐ No If yes, how much? __________

Do you smoke cigarettes, cigars, or other? ☐ Yes ☐ No If yes, how long? ______________

How much do you smoke? ______________________________

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many drinks per day? __________

Do you drink coffee, tea, or caffeinated soft drinks? ☐ Yes ☐ No

How many cups/cans of each per day? ______________________________

List any medications that you are presently taking, including the dosage:

____

____

____

Have you recently started on or made any changes in any medication(s) that you take on a regular basis?

☐ Yes ☐ No Explain: ______________________________

List any medications that you are allergic to: ______________________________

____

____

FAMILY HISTORY

Has any family member had a sleep disorder, such as:

Loud snoring	☐ Yes	☐ No	Narcolepsy	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No

Other (please describe): ______________________________

List any other medical problems common in your family: ______________________________

CURRENT MEDICAL PROBLEMS

Please list your current medical problems: ______________________________

____

____

____

Do you currently have any of the following conditions? (Please check all that apply):

☐ Excessive daytime sleepiness ☐ Impaired cognition ☐ Depression/Anxiety ☐ Insomnia

☐ High blood pressure ☐ Heart disease ☐ History of Stroke

PAST MEDICAL PROBLEMS

Please list and date any surgical procedures and hospitalizations you have had: Dates

____ ______________

____ ______________

____ ______________

REFERRAL SOURCE

How did you hear about the Hoag Sleep Disorders Center? ______________________________

______________________ ______________ ____________ A.M./P.M.

[Patient Signature] [Date] [Time]