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)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Seldom</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Gas” in your stomach, indigestion, or heartburn?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Gasping for breath, choking, or inability to breathe?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Asthma?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Excessive sweating throughout the night?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Headaches?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Chest pain(s)?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Irregular or pounding heart beats?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Leg cramps?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Crawling or aching feeling in your legs?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pain in your neck, back, spine, muscles, joints, or limbs?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Paresthesia (“pins &amp; needles”) in your limbs?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>An urgent desire to urinate?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bedwetting?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Frightening or recurring dreams?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sleep walking?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sleep talking?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other (describe):</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>With morning headaches?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>With pains in your arms or legs?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Coughing up excessive amounts of material?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Feeling unable to move (paralyzed)?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Having dream-like images even though you know you are not asleep?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>With pains in your jaw?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Somewhere other than where you went to sleep?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Confused, disoriented, or even violent?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
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: ______________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

REFERRAL SOURCE
How did you hear about the Hoag Sleep Disorders Center? ___________________________________________