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## Sleep Disorders Questionnaire

NAME: \_\_\_\_\_ DATE \_\_\_\_\_

AGE: \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_ HANDEDNESS R L

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ lbs COLLAR SIZE (MEN) \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

1. What is the main reason for this sleep disorders evaluation? (That is, what is your primary complaint?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How long has this been a problem? \_\_\_\_\_ months / years.

3. Have there been a sleep problem diagnosed in the past?                      yes no

If yes,

a) Where? \_\_\_\_\_

b) What was the problem? \_\_\_\_\_  
\_\_\_\_\_

c) What treatment(s) and did they help? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXCESSIVE SLEEPINESS**

1. Do you feel excessively tired or sleepy in the daytime ?                      yes    no

If yes, how long has this been occurring? \_\_\_\_\_months/years

2. Do you feel that your tiredness or sleepiness is a result of poor quality nighttime sleep?    yes                      no

3. Do you fall asleep unintentionally while:    (circle most accurate)

Reading	never	occasionally	frequently	always
Watching TV	never	occasionally	frequently	always
Conversation	never	occasionally	frequently	always
Meals	never	occasionally	frequently	always
Work	never	occasionally	frequently	always
Driving	never	occasionally	frequently	always

**THE EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 and circle the most appropriate number for the situation.

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

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

4. Ever had an accident or near-miss because of falling asleep while driving?    yes    no

If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever felt a sudden muscle weakness when you laughed, got angry, surprised, or while having sex?                      yes                      no

If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_







3. Do you ever grind or clinch your teeth at night? yes no
4. Did you wet your bed as a child? yes no  
 If yes, for how many years? \_\_\_\_\_
5. Have you ever wet your bed as an adult? yes no
6. Have you ever been told that you sleepwalk? in the past-- yes no Recently-- yes no
7. Have you been told you seem to act out dreams in your sleep? yes no

**PERSONAL HABITS, MEDICAL & PSYCHOLOGICAL HISTORY**

1. Do you currently have, or have you ever been diagnosed with:

High blood pressure	yes	no	Stroke	yes	no
Heart attack	yes	no	Congestive heart failure	yes	no
Asthma		yes no	COPD/Emphysema	yes	no
Seizures	yes	no	Head trauma	yes	no
Kidney disease	yes	no	Meningitis	yes	no
Diabetes	yes	no	Thyroid disease	yes	no
Arthritis	yes	no	Panic/Anxiety	yes	no
Parkinsons Dz		yes no	Depression	yes	no

Other \_\_\_\_\_

**MEDICATIONS**

2. Please list below the name and dose of all medications you are taking and state how often and for what reason you are take each one. If you take no medications write N/A.

	NAME	DOSE	HOW OFTEN	REASON
a)	_____	_____	_____	_____
b)	_____	_____	_____	_____
c)	_____	_____	_____	_____
d)	_____	_____	_____	_____
e)	_____	_____	_____	_____
f)	_____	_____	_____	_____
g)	_____	_____	_____	_____
h)	_____	_____	_____	_____
i)	_____	_____	_____	_____

3. Do you use oxygen? yes no Do you have a pacemaker? yes no

4. Do you any allergies to medications? yes no

If yes, which ones: . \_\_\_\_\_  
 . \_\_\_\_\_  
 . \_\_\_\_\_

5. Do you have any other allergies? yes no

List them: . \_\_\_\_\_  
 . \_\_\_\_\_

