BLUE RIDGE SLEEP MEDICINE
SLEEP HABITS QUESTIONNAIRE

- Bring this form with you to your sleep consultation
- Bring this form with you to your sleep test

Please answer the following questions as completely as you can. Use the assistance of a bed partner or other observer of your sleep if possible. If the patient's and the observer's answers do not agree, include BOTH answers and indicate which answer is which. When "night" is mentioned, it means your longest, regular period of sleep. When "day" is mentioned, it means the rest of the time. All information is confidential and not accessible as part of your medical record without your consent.

This is an extensive and detailed questionnaire. It may take 30 to 60 minutes to complete. It is important to fill it out completely to ensure you get the proper evaluation and treatment.

Name_____Date_____

Street Address_____

City_____ State_____ Zip_____ SS# _____

Home Phone_____ Work Phone_____

Occupation and Employer _____

Marital Status: Single____ Married____ Separated_____ Divorced_____ How Long?_____

Birth date_____ Age_____ Sex_____ Height_____ Weight_____

Your Weight One Year Ago _____ 5 Years Ago_____ 10 Years Ago_____

Referred By_____ Group Name_____

Office Phone_____ Specialty_____

Primary Care Physician_____ Group Name_____

Address_____ Phone_____

Please describe your sleep problem. If you don't think you have a sleep problem, please tell us why you have come to the Sleep Center for evaluation: _____

_____

_____

1) What time do you usually go to bed? (work nights)_____ (other nights)_____

2) What time do you usually get up? (work days)_____ (other days)_____

3) Do you use an alarm clock to get up? No_____ Yes_____

4) Do you feel better with extra sleep? No_____ Yes _____

5) Do you have trouble falling asleep? No ____ Yes _____ How long does it take you to fall asleep?_____

If you do have trouble falling asleep, why do you think this is?

_____

6) Do you have trouble staying asleep? No _____ Yes _____ If yes, why do you think this is?

_____

7) If you wake up during the night, do you have trouble falling back asleep? No_____ Yes _____

8) Do you have fears or anxieties about having trouble sleeping? No _____ Yes _____

9) Does anything help you sleep at night? _____

10) Do you nap during the day? No _____ Yes _____

11) **Please rate how often you:**

	Never	Rarely	Sometimes	Frequently	Constantly
Have vivid dream-like scenes upon awakening or going to sleep (dream while awake)	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Experience loss of muscle tone when extremely emotional	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs	_____	_____	_____	_____	_____
Toss and turn while sleeping	_____	_____	_____	_____	_____
Urinate frequently at night	_____	_____	_____	_____	_____
Sweat excessively during the night	_____	_____	_____	_____	_____
Have difficulty waking up in the morning	_____	_____	_____	_____	_____
Awaken from sleep short of breath	_____	_____	_____	_____	_____
Awaken with dry mouth	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching or with cough/wheezing	_____	_____	_____	_____	_____
Awaken at night with your heart pounding or beating irregularly	_____	_____	_____	_____	_____
Awaken with a headache	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Have “sleep attacks” during the day	_____	_____	_____	_____	_____
Snore	_____	_____	_____	_____	_____

12) With 10 being the loudest, how would you rate your snoring on a scale from 1 to 10 ? _____

13) Do you relate your snoring to weight gain or any other medical conditions? No_____ Yes _____ What other conditions?

_____

14) Do you experience fatigue, sleepiness, or decreased energy during the day? No_____ Yes_____

15) Is there anything that you think is important about your sleep that is not addressed above?

_____

_____

_____

_____

16) Have you ever been treated by a Psychiatrist, Psychologist, or other mental health professional?
No_____ Yes_____ If yes, please indicate when you were treated and for what type of problem: _____

_____

_____

17) Are you in good health? No_____ Yes_____

Give details: _____

18) Please place a check mark next to any conditions you have ever had:

_____Anemia
_____Arthritis
_____Asthma
_____Breathing trouble at night
_____Chronic pain
_____Decreased sexual interest
_____Dental problems
_____Depression
_____Diabetes
_____Drug or alcohol problems
_____Emphysema
_____Epilepsy or seizures
_____Fibrositis
_____Frequent headaches
_____Hallucinations or delusions
_____Head injury or surgery
_____Heart attack
_____Heartburn/ulcers
_____Heart disease/heart failure
_____Hiatal hernia
_____High blood pressure
_____Hyperactivity as a child
_____Kidney problems
_____Nose and throat problems
_____Panic attacks
_____Parkinson's disease
_____Severe anxiety or nervousness
_____Sexual problems
_____Shortness of breath
_____Suicide attempts
_____Thyroid problems
_____Wear dentures

19) Do you have any medical problem not listed above? No_____ Yes_____

If yes, please list: _____

_____

_____

20) Please list any surgeries or hospitalizations: List the year, operation and reasons for any hospitalizations: _____

_____

_____

21) Do you take any medications (by prescription or over-the-counter)? No_____ Yes_____

Please list and give details:

Name of Drug	Amount/dose	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

22) List any medication allergies: _____

_____

_____

23) Do you drink alcoholic beverages? No_____ Yes_____ If yes, on the average, how many alcoholic beverages do you drink: On weekends? _____drinks per day On weekdays? _____drinks per day

24) Do you smoke or use tobacco? No____ Yes _____If yes, what kind of tobacco?_____ How often?_____

25) Do you drink coffee or caffeinated beverages? No_____ Yes_____ If yes, how much? _____cups/drinks per day

26) How late in the day do you drink caffeinated beverages? _____

27) List any medical conditions and/or illnesses that run in your family: _____

28) **Remarks:** If there are any other aspects of your sleep problem that you feel are important, please describe them in this space: _____

_____

_____

THE MODIFIED EPWORTH SLEEPINESS SCALE

Please rate how likely you are 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 activities recently, try to work out how they would affect you. Use the following 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
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon (when circumstances permit)	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch	_____
In a car, while stopped for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION

BEDPARTNER'S (BP) QUESTIONNAIRE FOR EXCESSIVE DAYTIME SLEEPINESS

To the Patient: Please have your BEDPARTNER (BP) complete this form.
Return it with the other sleep forms.

To the Patient's Bedpartner: Please complete this form, giving us YOUR observations of the patient's condition.

Patient's Name: _____

Your Name: _____ Today's Date: _____

1) What is your BP's problem? (Describe in Detail): _____

_____

_____

2) Does your BP snore? Yes_____ No_____
If yes, how long have you known your BP to snore (indicate months, years, etc.)? _____

3) Does he/she snore on his/her:

Back	No_____	or	Moderately Loud_____	Very Loud_____
Sides	No_____	or	Moderately Loud_____	Very Loud_____
Stomach	No_____	or	Moderately Loud_____	Very Loud_____

4) Do you consistently sleep in the same bedroom? Yes_____ No_____

If no, why? _____

5) How long have you slept in separate rooms? (indicate months, years, etc.)_____

6) Does your BP seem to stop breathing in his/her sleep? Yes_____ No_____

If yes, how long has this occurred? (indicate months, years, etc.)_____

If yes, how long are the pauses in breathing?_____
If yes, does he/she gasp for air afterwards? Yes_____ No_____

7) Does your BP move around in bed? Yes_____ No_____
If yes, does he/she toss and turn? Yes_____ No_____
If yes, are the movements small, regular, leg movements? Yes_____ No_____

8) Does your BP grind his/her teeth in their sleep? Yes_____ No_____

9) Is your BP sleepier than you most of the time? Yes_____ No_____
If yes, will he/she nap before bedtime? Yes_____ No ____

If yes, how often? _____days per week or _____days per month

10) Will your BP fall asleep?:

In church	Yes_____	No_____
While driving	Yes_____	No_____
With company	Yes_____	No_____

THE MODIFIED EPWORTH SLEEPINESS SCALE
FOR YOUR BEDPARTNER

PATIENT NAME:_____

YOUR NAME (Bedpartner):_____

TODAY'S DATE:_____ AGE:_____ SEX:_____

TO THE PATIENT: Please have your BEDPARTNER complete this form and return it with the other forms.

TO THE BEDPARTNER: Please complete this form, giving us your observations of the patient's condition.

How likely is your bedpartner to doze off or fall asleep in the following situations, in contrast to "just feeling tired?" This refers to his/her usual way of life in recent times. Even if he/she has not done some of these activities recently, try to work out how they would affect your bedpartner. Use the following 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
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon (when circumstances permit)	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION
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