

This questionnaire helps us zero in on your sleep problems. We pay close attention to your answers, so please be as detailed and complete as you can. Please remember to fill out both sides of each sheet.

What is your occupation? _____

List your main sleep problems (please estimate how long you've had each problem)

1. _____ 3. _____
 2. _____ 4. _____

Have you ever had a sleep study before? Yes ___ No ___ What year? _____	
Name of sleep center where study was done: _____	
Are you currently using oxygen, CPAP or an oral appliance for sleep apnea? Yes ___ No ___ Supplier: _____	
Have you had airway surgery for obstructive sleep apnea? Yes ___ No ___ Surgeon: _____ Date: _____	
What medications or supplements, if any, have you tried for your sleep problem(s)? _____	
What other things have you tried to help your sleep problem(s)? _____	

On weeknights, about when do you go to bed? _____
On weeknights, about how long does it take you to fall asleep? _____
On weeknights, about how many hours do you sleep? _____
On weekdays, when does your alarm go off? _____
Do you sleep through the night? Yes: <input type="checkbox"/> No: <input type="checkbox"/> If not, how many interruptions on average? _____
Are you aware of what interrupts your sleep? If so, what? _____
Is your sleep different on weekends/holidays/days off? If so, how? _____
If you could rearrange your life so things would be perfect, when would you ideally like to fall asleep? _____
When would you ideally like to wake up? _____

Have any of your blood relatives (parents, siblings, children, cousins, grandparents, uncles/aunts) had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Parkinson's disease or tremor |
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Excessive sleepiness | <input type="checkbox"/> Attention deficit/hyperactivity | <input type="checkbox"/> Other: _____ |

What education level have you completed? _____	What is your marital status? _____
Do you have children? If so, what are their ages? _____	What hours do you work? _____
Stress level at WORK is: Nonexistent: <input type="checkbox"/> Low: <input type="checkbox"/> Medium: <input type="checkbox"/> High: <input type="checkbox"/> List stressors, if any: _____	
Stress level at HOME is: Nonexistent: <input type="checkbox"/> Low: <input type="checkbox"/> Medium: <input type="checkbox"/> High: <input type="checkbox"/> List stressors, if any: _____	

Name: _____ Date: _____

Current Medical Problems, if any (i.e., high blood pressure, diabetes, heart problems, low thyroid, depression, etc)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Past major medical problems, if any (i.e., head injury, operations, major illnesses, accidents) – please list approximate year of occurrence

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Current medications, vitamins and supplements (please list doses also)

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Please list any prescription medications that you've taken then discontinued (other than antibiotics or other short term treatments) – please list the reason for discontinuation, if you can remember

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Allergies or bad reactions to medications (please indicate what problem the medication caused)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how much per DAY on average?
Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how much per WEEK on average?
Do you drink coffee, tea, soda or energy drinks (circle all that apply)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how much per DAY on average?
Do you use recreational drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, what do you use? How much per week?
Have you ever been through a drug or alcohol detox program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, when?

Your current weight (pounds)_____	Your height (feet/inches)_____	Your neck size:_____	
Over the past year, has your weight been:	Increasing: <input type="checkbox"/>	Decreasing: <input type="checkbox"/>	Stable: <input type="checkbox"/>

Using the scale below, please list how often you've experienced the following symptoms or situations recently. Circle only one letter per line.

D	F	O	S	N	?
Daily or almost daily	Frequently (1 – 3 times per week)	Occasionally (1 – 3 times per month)	Seldom (less than once per month)	Never	Not sure

- | | | | | | |
|-------------|--|--|--|-------------|---|
| D F O S N ? | 1 Nodding off without meaning to | | | | |
| D F O S N ? | Difficulty getting up in the morning | | | D F O S N ? | 11 Awakened by children |
| D F O S N ? | Daytime napping | | | D F O S N ? | Awakened by bed partner |
| D F O S N ? | Afternoon drowsiness | | | D F O S N ? | Awakened by pets |
| D F O S N ? | After dinner drowsiness | | | D F O S N ? | Awakened by outside noises or lights |
| D F O S N ? | 2 Drowsiness interferes with work or school | | | D F O S N ? | Awakened by uncomfortable mattress |
| D F O S N ? | Drowsiness makes it difficult to drive | | | D F O S N ? | 12 Fall asleep watching TV |
| D F O S N ? | Drowsiness interferes at home | | | D F O S N ? | Fall asleep on couch or recliner |
| D F O S N ? | Drowsiness interferes with social life | | | D F O S N ? | Use alcohol to help fall asleep |
| D F O S N ? | 3 Easily fatigued/need to rest frequently | | | D F O S N ? | Use sleeping medication to help fall asleep |
| D F O S N ? | Fatigue interferes with work or school | | | D F O S N ? | Use food to help fall asleep |
| D F O S N ? | Fatigue interferes at home | | | D F O S N ? | 13 Stuffy or runny nose |
| D F O S N ? | Fatigue interferes with social life | | | D F O S N ? | Sinus fullness or pain |
| D F O S N ? | 4 Thoughts won't quiet down at bedtime | | | D F O S N ? | Tooth grinding or clenching |
| D F O S N ? | Take longer than an hour to fall asleep (assuming no sleeping medication) | | | D F O S N ? | TMJ (jaw joint) pain |
| D F O S N ? | Wake three or more times per night | | | D F O S N ? | Hoarseness |
| D F O S N ? | Can't get back to sleep if awakened | | | D F O S N ? | Sore throat |
| D F O S N ? | Frustrated because of inability to sleep | | | D F O S N ? | 14 Wheezing |
| D F O S N ? | 5 Feeling down or blue much of the day | | | D F O S N ? | Coughing |
| D F O S N ? | Decreased interest in social activities | | | D F O S N ? | Shortness of breath |
| D F O S N ? | Feelings of guilt or remorse | | | D F O S N ? | Rapid or irregular heartbeat |
| D F O S N ? | Decreased interest in sex | | | D F O S N ? | Swelling of the extremities (edema) |
| D F O S N ? | Change in appetite (<input type="checkbox"/> decrease or <input type="checkbox"/> increase) | | | D F O S N ? | Chest pain or heaviness |
| D F O S N ? | Thoughts that life is not worth living | | | D F O S N ? | 15 Acid reflux/heartburn (assuming you didn't take antacid medication) |
| D F O S N ? | 6 Difficulty learning new things | | | D F O S N ? | Abdominal pain or cramping |
| D F O S N ? | Difficulty getting organized | | | D F O S N ? | Diarrhea |
| D F O S N ? | Overwhelmed by complicated tasks | | | D F O S N ? | Bloating or belching |
| D F O S N ? | Difficulty staying focused on reading material | | | D F O S N ? | 16 Night sweats |
| D F O S N ? | Difficulty staying focused at work or school | | | D F O S N ? | Wake up feeling hung over |
| D F O S N ? | 7 Anxious, nervous or edgy much of the day | | | D F O S N ? | Waking with a dry mouth |
| D F O S N ? | Fear of being in tight, enclosed spaces | | | D F O S N ? | Get up to urinate more than once per night |
| D F O S N ? | Easily startled | | | D F O S N ? | 17 Achy joints |
| D F O S N ? | Nightmares or disturbing dreams | | | D F O S N ? | Achy or tender muscles |
| D F O S N ? | Recurrent obsessive thoughts | | | D F O S N ? | Awakened by muscle or joint pain |
| D F O S N ? | 8 Irritable much of the day | | | D F O S N ? | Awakened by muscle cramps |
| D F O S N ? | Easily upset | | | D F O S N ? | 18 Morning headache |
| D F O S N ? | Impatient with others | | | D F O S N ? | Daytime or evening headache |
| D F O S N ? | Loss of temper/anger outbursts | | | D F O S N ? | Back pain |
| D F O S N ? | 9 Restless/uncomfortable feelings in the body | | | D F O S N ? | Numbness, burning or tingling of extremities |
| D F O S N ? | Urges to move arms or legs while awake | | | D F O S N ? | Carpal tunnel symptoms (aching of wrists or forearms) |
| D F O S N ? | Urge to move interferes with getting to sleep | | | D F O S N ? | Pain interferes with getting to sleep |
| D F O S N ? | Twitching or jerking of limbs while awake | | | D F O S N ? | Awakened by pain after falling asleep |
| D F O S N ? | Tossing and turning while asleep | | | D F O S N ? | 19 Satisfied with quality of sleep |
| D F O S N ? | 10 Snoring | | | D F O S N ? | Satisfied with amount of sleep |
| D F O S N ? | Breathing stops while asleep | | | D F O S N ? | Satisfied with daytime energy |
| D F O S N ? | Breathing alternates between shallow and deep while asleep | | | D F O S N ? | Satisfied with daytime alertness |
| D F O S N ? | Awakened by gasping or choking | | | | |

Name: _____ Date: _____