

# RALEIGH NEUROLOGY SLEEP MEDICINE PROGRAM



## SLEEP STUDY QUESTIONNAIRE

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### PART I: GENERAL INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex M  F

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

What is (or was) your body weight: A. Now \_\_\_\_\_ lb. B. When age 20 \_\_\_\_\_ lb. C. When heaviest ever \_\_\_\_\_ lb.

Height \_\_\_\_\_ Do you know your neck size in inches? \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Allergies Medications No  Yes  \_\_\_\_\_

Environmental No  Yes  \_\_\_\_\_

### PART II: SLEEP HISTORY

1. Please describe your sleep disturbance: \_\_\_\_\_

2. How long have you had this problem? \_\_\_\_\_

3. On average, what is your normal bedtime? \_\_\_\_\_

On average, what time do you get out of bed in the morning? \_\_\_\_\_

4. Estimate how many hours of sleep you get: A. On the average night \_\_\_\_\_ B. On a bad night \_\_\_\_\_

5. How long does it take you to fall asleep? A. On the average night \_\_\_\_\_ B. On a bad night \_\_\_\_\_

6. Do you sleep better away from home (vacation, business travel, etc.)? Yes  No

7. How many times do you wake up during the night? A. On the average night \_\_\_\_\_ B. On a bad night \_\_\_\_\_

8. Has anyone else told you that you snore loudly? Yes  No

If yes, has your snoring caused people to refuse to sleep in the same room? Yes  No

9. Please indicate if you have noticed (or someone has told you) that you:

A. Suddenly wake up gasping for breath or short of breath Yes  No

with a morning headache Yes  No

C. Snort yourself awake Yes  No

D. Notice your legs jerking or twitching during the night Yes  No

E. Wake up confused and wander during the night Yes  No

F. Are you unable to move when falling asleep or immediately upon waking Yes  No

G. Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry or in other emotional situations Yes  No

H. Have vivid or life-like visual images while falling asleep or upon awakening? Yes  No

I. Have had witnessed apnea (Stop Breathing) Yes  No

**PART III: PARASOMNIA SCREEN** Do you do any of the following:

- |   |                               |  |
|---|-------------------------------|--|
| A.* Act out your dreams                                       | Yes <input type="checkbox"/>  | No <input type="checkbox"/>                              |
| B.* Wake up screaming   | Yes <input type="checkbox"/>  | No <input type="checkbox"/>                              |
| C.* Perform repetitive or seemingly purposeless acts at night | Yes <input type="checkbox"/>  | No <input type="checkbox"/>                              |
| D.* Wake up appearing confused and then return to sleep       | Yes <input type="checkbox"/>  | No <input type="checkbox"/>                              |
| E.* Grind your teeth at night                                 | Yes <input type="checkbox"/>  | No <input type="checkbox"/>                              |
| F.* Walk in your sleep  | If yes, how frequently? _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> |

*\*Consult your bed partner*

**PART IV: RLS SCREEN**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| A. Do you have an urge to move your legs—usually accompanied or caused by uncomfortable leg sensations? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| B. Is there relief with movement—partial or total relief from discomfort by walking or stretching?      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| C. Is the onset or worsening of symptoms at rest or inactivity—such as when lying or sitting?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| D. Is the onset or worsening of symptoms in the evening or at night?                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**PART V: SLEEP HYGIENE**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| A. Do you exercise?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, describe your routine, include time of exercise _____   |                              |                             |
| B. Do you take a hot bath or shower within 2 hours of bed?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| C. Do you eat within 3 hours of bed?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If so, what and how much _____  |                              |                             |
| D. What activities do you engage in while in the bedroom setting, aside from sex or sleep (i.e. work, TV, reading, etc.)? | _____                        |                             |
| E. Are there any problems that interfere with your sleep (such as noise, temperature in house, bed partner)?              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| F. Do you have problems with thoughts running through your mind at night?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please describe: _____  |                              |                             |
| _____   |                              |                             |

**PART VI: DAYTIME FUNCTIONING**

- |  |                                     |  |
|--|-------------------------------------|--|
| 1. Do you have a problem with severe sleepiness (feeling sleepy or struggling to stay awake) during the daytime?                 | Yes <input type="checkbox"/>        | No <input type="checkbox"/>                              |
| 2. Do you often have a problem with your performance at work because of sleepiness?  | Yes <input type="checkbox"/>        | No <input type="checkbox"/>                              |
| 3. Have you ever had car accidents caused by your sleepiness (not due to drugs or alcohol)?                                      | Yes <input type="checkbox"/>        | No <input type="checkbox"/>                              |
| 4. Have you ever had near car accidents (for example, driving off the road) because of sleepiness (not due to drugs or alcohol)? | If yes, how many times? _____       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Do you fall asleep without meaning to during the day?   | Yes <input type="checkbox"/>        | No <input type="checkbox"/>                              |
| If yes, how many times during the average week? _____  |                                     |  |
| 6. How many naps do you take during the average week? _____ per week   | How long is your average nap? _____ |  |
| 7. At what time of day do you feel the most fatigued/sleepy? _____   |                                     |  |
| 8. Does your job require that you change shifts?   | Yes <input type="checkbox"/>        | No <input type="checkbox"/>                              |
| If yes, please describe: _____   |                                     |  |

**PART VII: EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 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 (e.g. theatre or a meeting)	_____
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 traffic	_____
	TOTAL _____

**PART VIII: MEDICAL HISTORY**

Please check if **YOU** have ever had any of the following conditions:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Low back pain                  |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Dementia                    | <input type="checkbox"/> Migraine headaches             |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Epilepsy or seizures        | <input type="checkbox"/> Multiple sclerosis             |
| <input type="checkbox"/> Atrial fibrillation   | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Parkinson’s disease            |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hallucinations or delusions | <input type="checkbox"/> Neuropathy                     |
| <input type="checkbox"/> CHF                   | <input type="checkbox"/> Heart attack                | <input type="checkbox"/> Problems with alcohol or drugs |
| <input type="checkbox"/> Chronic pain          | <input type="checkbox"/> Hiatal hernia               | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Chronic sinus disease | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Ulcer/heartburn                |
| <input type="checkbox"/> COPD                  | <input type="checkbox"/> High cholesterol            |   |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Hyper/hypo thyroidism       |   |

Other (please describe) \_\_\_\_\_

**PART IX: SURGICAL HISTORY**

Please list any previous surgeries and dates:

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

**PART X: MEDICATIONS**

Please list all medications you are **CURRENTLY** taking:

	Medicine	Dose	Frequency	Reason
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

Please list all **PREVIOUS** sleeping medications:

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

How much of the following do you consume during the **AVERAGE DAY**?

- a) alcohol \_\_\_\_\_
- b) coffee (with caffeine) \_\_\_\_\_
- c) tea (with caffeine) \_\_\_\_\_
- d) soft drinks (with caffeine) \_\_\_\_\_
- e) cigarettes \_\_\_\_\_
- f) other tobacco products \_\_\_\_\_

**PART XI: FAMILY MEDICAL HISTORY**

Please list any pertinent **FAMILY** medical problems (particularly sleep problems):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART XII: OTHER INFORMATION**

Please add any other information that you feel is important:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_