PRELIMINARY SLEEP QUESTIONNAIRE

Please answer all of the following questions and bring this questionnaire with you to your appointment.

Name (Last)_____ (First)_____ (MI)__ DOB_____Date_____

Briefly describe your problem

_____

_____

_____

How long have you had your sleep-related problems?_____years/months

Using the following rating scale, to what extent do you currently experience the following symptoms? (If not applicable, circle N/A)

	MILD			MODERATE				SEVERE			
Daytime Sleepiness	1	2	3	4	5	6	7	8	9	10	N/A
Snoring	1	2	3	4	5	6	7	8	9	10	N/A
Difficulty Falling Asleep	1	2	3	4	5	6	7	8	9	10	N/A
Difficulty Staying Asleep	1	2	3	4	5	6	7	8	9	10	N/A
Walking, Talking or other Unusual Behaviors During Sleep	1	2	3	4	5	6	7	8	9	10	N/A
Daytime Deficits in Concentration, Memory, Motivation or Mood	1	2	3	4	5	6	7	8	9	10	N/A
Obtain too little sleep	1	2	3	4	5	6	7	8	9	10	N/A
Obtain too much sleep	1	2	3	4	5	6	7	8	9	10	N/A

At what time do you typically go to bed and awake?
On weekdays (Sun-Thurs) _____ On weekends (Fri-Sat) _____

How long does it take you to fall asleep?_____
How many times do you typically awaken during the night?_____

On a typical night, is your sleep disturbed by any of the following?

Asthma	YES	NO	Heartburn	YES	NO
Nightmares	YES	NO	Difficulty breathing	YES	NO
Persistent cough	YES	NO	Choking or need for air	YES	NO
Regurgitation	YES	NO	Nasal congestion	YES	NO
Panic	YES	NO	Sweating	YES	NO

Heart pounding	YES	NO	Racing thoughts, worries	YES	NO
Headache	YES	NO	Restless legs/need to move	YES	NO
			Noises in sleep area	YES	NO
Muscle cramps	YES	NO	Bed partner	YES	NO
			Child/pet care needs	YES	NO
Thrashing movements	YES	NO	Heat or cold	YES	NO
Hunger or thirst	YES	NO	Light in sleep area	YES	NO
			Need to urinate/night	0 1 2 3 4 5	

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up) (This is your Epworth score)	____

Past Medical History: (Please check if applicable)

___ High Blood Pressure ___ Diabetes ___ Stroke ___ Heart Problems ___ Lung Problems
___ Glaucoma ___ Cancer ___ Anemia ___ Liver disease ___ Blood Clots
___ Epilepsy ___ Gastrointestinal ___ Gynecological Problems
Other: _____

Surgical History: _____

_____

Habits: Alcohol _____ # drinks/week Cigarettes _____ # cig/day x _____ # years _____ year quit

Other tobacco usage: _____ Current frequency: _____
Caffeine _____ # cups/day Recreational Drugs: _____

Family History:

_____ Migraine	_____High Blood Pressure	_____ Cancer
_____ Epilepsy	_____ Diabetes	_____ Anemia
_____Cerebral Aneurysm	_____ Stroke	_____ Liver Disease
_____Multiple Sclerosis	_____ Heart Problems	_____ Blood Clots
_____Parkinsons	_____ Lung Problems	_____ Osteoporosis
_____Alzheimer/Dementia	_____ Glaucoma	

Other: _____

Allergies: _____

Current Medications:

Medication	Dosage	Reason

Review of Current/Recent Symptoms: (check all that are applicable)

General: ___ Fever ___ Chills ___ Weight Loss ___ Weakness

Skin: ___ Rash ___ Itching

Hematopoietic: ___ Bruising ___ Bleeding ___ Anemia

HEENT: ___ Vision changes ___ Double vision ___ Glaucoma ___ Hearing problems ___ Vertigo

Respiratory: ___ Cough ___ Coughing Blood ___ Shortness of Breath ___ Infections

Cardiovascular: ___ Chest Pain ___ Murmurs ___ Pain in legs with walking ___ Swelling in the legs

Gastro-Intestinal: ___ Constipation ___ Diarrhea ___ Bleeding ___ Hemorrhoids ___ Indigestion ___ Hepatitis

Genito-Urinary: ___ Burning ___ Bleeding leaking (incontinence) ___ Flank pain ___ Loss of erections

Muscle-skeletal: ___ Joint Pain ___ Weakness ___ Back pain ___ Cramps

Neurologic: ___ Headache ___ Dizziness ___ Seizures ___ Blackouts ___ Depression ___ Sleeping problems

Other:_____

_____

Other Comments:_____

_____

_____ _____

Signature Date