Sleep Questionnaire

Personal information

Name: _____ Social Security Num. _____

Date: _____ Weighs _____ Height _____ Date of Birth _____

Sleeping Habits

4. Working time Day Shifts Night Not working

5. Usual hour of going to bed a.m. Week _____ / p.m. Weekend _____ a.m. / p.m.

6. Usual hour of getting up a.m. Week _____ / p.m. Weekend _____ a.m. / p.m.

7. Usually, how many hours do you sleep per night? _____ Hours

8. Usually, how long do you take to fall asleep? _____ Minutes

9. Do you have difficulty in falling asleep? Yes No

10. Do you have difficulty in staying asleep? Yes No

11. With what frequency do you awake during the night?

a ..... Rarely

b. ..... 3 or less

c. ..... Frequently

12. Do you get up during the night to go to the bathroom? Yes No

13. When you get up do you drink or eat before going to bed again? Yes No

14. Do you wake up for more than 30 minutes during the night? Yes No

15. Do you sleep in a noisy place? Yes No

16. Do you sleep with the radio or the TV on? Yes No

17. Do you awake too early and have difficulty to reconcile sleep? Yes No

Do you **stay** in bed or do you **get up**? _____

18. Do you use **alarm** clock to wake up in the mornings or by your **own** account? _____

19. Do you feel rested in the morning after sleeping? Yes No

20. Does the quality of your sleep interfere with work or social life? Yes No

21. How many nights per week do you have difficulties with your sleep? _____ Nights

Observations of your sleep, by you and others

22. Have you been told that you snore? Yes No

Since when? _____ Years

23. Have you been told that you stop breathing while asleep? Yes No

24. In what position you usually sleep? _____

In what position your snoring worsen? _____

In what position your breathing problem worsen? _____

25. Do you wake up gasping for air, unable to breath during the night? Yes No

26. Do you wake up with Headache? Yes No

27. Have you been told that your arms or legs jump while sleeping? Yes No

28. Do you have the urgency to move a lot; to get up and stretch your legs? Yes No

29. Do you suffer of cramps in the legs? Yes No

30. Do you suffer of muscular pains during the night? Yes No

31. Do you suffer of nightmares? Yes No

32. Do you wake up confused? Yes No

Daytime symptoms

33. Do you take Naps? Yes No

Do you feel rested after a nap? Yes No

34. Have you been diagnosed of Narcolepsy? Yes No

35. Do you feel muscular weakness or muscular paralysis when you laugh, or when angry? Yes No

36. Have you wakened up feeling paralyzed in the morning and without being able to move? Yes No

37. Have you been told or notice been irritable recently? Yes No

38. Are you having difficulty to memorize or to concentrate? Yes No

39. Are you suffering of anxiety? Yes No

40. Are you suffering of depression? Yes No

41. Do other members of your family have sleeping problems? Yes No

42. Is there family record of snores or sleeping problems? Yes No

If affirmative, Who?: _____

(Women Only)

43. When was your last menstruation? _____

44. Do you notice any difference with your sleep during this time? Yes No

45. Are you in Post-menopause? Yes No

46. Do you take substitution of hormones? Yes No

How likely are you to doze off or fall asleep in the following situation 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 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

	0	1	2	3
Sitting and reading.....				
Watching TV.....				
Sitting, inactive in a public place (e.g. a theater or meeting).....				
As a passenger" in a car for an hour 'Without a break.....				
lying down to rest in the afternoon when circumstances permit it.				
Sitting and talking to someone.....				
Sitting quietly after a lunch without alcohol.....				
in a car, while stopped for a few minutes in traffic.....				
Total				

Other Medical Information

57. Do you have History of: (mark all those that apply)

[ ] High pressure [ ] Heart [ ] Chest Pain [ ] Indigestion [ ] throat Infection [ ] Emphysema [ ] Asthma [ ] COPD

[ ] Chronic nasal/sinus congestion [ ] Wake up coughing [ ] Kidneys [ ] Arthritis [ ] Diabetes [ ] Prostate [ ] Thyroid

[ ] Night Perspiration [ ] Back [ ] Muscular Pain [ ] Sleep talking [ ] Somnambulism [ ] Headache [ ] Depression

[ ] Incontinence

58. Did you had your tonsils removed? Yes No

59. Have you broken your nose at some time? Yes No

60. Have you gained weight? Yes No

If affirmative, _____ pounds in _____ years?

61. Mention other medical problems:

_____

_____

_____

_____

62. Mention all the medications that you are taking at this moment: (prescribed and not prescribed)

_____

_____

_____

_____

63. Do you consume alcoholic drinks? Yes No

If affirmative, how much (choose one)

a. rarely

b. 2 ounces of alcohol or 2 daily beers or less

c. 4 ounces of alcohol or 4 daily beers or less

d. live than 4 ounces of it up-to-dates alcohol

64. Do you consume Caffeine-containing beverages? Yes No

coffee _____ cups/daily

Tea _____ glass/daily

Caffeine-containing carbonated beverages _____ cans/glass

Chocolates _____ bars/ounces

65. Do you smoke? Yes No

If affirmative, for how long? _____ About how much a day? _____

66. Did you smoke? Yes No

If affirmative When did you stop smoking? _____ About how much you used to smoke a day? _____

Therapies

67. Have you been diagnosed of the condition of sleep Apnea? Yes No

If affirmative, where and when was the study made?

_____

68. Have you gone through surgeries, taken medication or received treatments for sleep problems in the past? Yes No

(If affirmative, respond to the questions from the 69 to the 73)

69. Used oxygen for sleep? Yes No

If affirmative, How many liters? _____

70. Have you gone through surgeries for sleep problems in the past? Yes No

If affirmative, Where and which procedure was practiced?

_____

71. Do you use a CPAP or Bi-PAP to sleep? Yes No

If affirmative, at what pressure? _____cm/H20

72. Do you feel any difference when using the CPAP/Bi-Level? Yes No

Explain: _____

_____

_____

_____

73. Additional information of other medical problems related with your sleep:

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for the time dedicated in responding to our questions. Please, bring this questionnaire the night of the study.

SAN PABLO SLEEP DISORDER CENTER

(787)786-8196 FAX (787)786-6780