SLEEP & NEUROSCIENCE ASSOCIATES

Consultation Questionnaire

1. What is your chief complaint related to your sleep? Why are you seeking treatment at this time?

____
____
____
____
____

Sleep environment and bedtime routine

2. Are you bothered by the lighting conditions of your bedroom during sleep? ❑ Yes ❑ No
3. Is your bedroom too hot or too cold during sleep? ❑ Yes ❑ No
4. Are you bothered by noise during sleep? ❑ Yes ❑ No
5. Is your bed or bedding uncomfortable? ❑ Yes ❑ No
6. Do you sleep with anyone else in the same room or the same bed? ❑ Yes ❑ No
   - If yes, are you bothered by your roommate's or bed partner's snoring or movements during sleep? ❑ Yes ❑ No
   - If yes, do you sleep in the same room or same bed with your children? ❑ Yes ❑ No
7. Do you sleep in the same bed with a pet? ❑ Yes ❑ No
8. What is your usual bedtime (the time your get into bed)? _____ AM / PM
9. What is your usual rise time (the time you get out of bed)? _____ AM / PM
10. Does your bedtime and rise time fluctuate from day to day? ❑ Yes ❑ No
11. Do you change your bedtime and rise time on the weekends or on days that you do not work? ❑ Yes ❑ No
    - If yes, what is your usual bedtime on weekends or non-work days? _____ AM / PM
    - If yes, what is your usual rise time on weekends or non-work days? _____ AM / PM
12. How long does it usually take you to fall asleep after you get into bed? _____ mins
13. How many times do you usually awaken during the sleep period? _____ times
14. What is the average duration of your awakenings? _____ mins
15. On average, how long would you say you actually are asleep each night? _____ hrs _____mins
16. Do you have a regular, nightly routine that you follow every night before getting into bed? ❑ Yes ❑ No

If yes, what do you usually do?

____

____

17. Do you read, watch TV, browse the internet or play wth your hand held device while in bed before sleep onset? ▢ Yes ▢ No

Daily functioning

18. Do you usually feel sluggish, sleepy, or fatigued upon awakening in the morning? ▢ Yes ▢ No
19. Do you usually feel fatigued throughout the day? ▢ Yes ▢ No
20. Are you bothered by low mood, irritability, or anxiety during the day? ▢ Yes ▢ No
21. Are you bothered by problems with attention, concentration, or memory during the day? ▢ Yes ▢ No
22. Do you find it hard to persist at things you are doing, even simple things? ▢ Yes ▢ No
23. Are you usually bothered by sleepiness during the day? ▢ Yes ▢ No
24. Do you feel that you've lost motivation to do things, or that you've lost interest or pleasure in activities that you used to enjoy? ▢ Yes ▢ No
25. Has your sex drive (libido) diminished? ▢ Yes ▢ No
26. For Men, Do you have trouble getting or maintaining erections? ▢ Yes ▢ No
27. Do you tend to fall asleep in sedentary situations (for example, while watching television, working at a computer, in meetings)? ▢ Yes ▢ No
28. Do you tend to fall asleep at inappropriate times? ▢ Yes ▢ No
29. Has your sleepiness or falling asleep ever put you or someone else in danger? ▢ Yes ▢ No

    If yes, please give an example: ____________________________________

30. Have you had a motor vehicle accident due to sleepiness or fatigue? ▢ Yes ▢ No
31. Do you usually nap during the day? ▢ Yes ▢ No

    If yes:

    How long do you usually nap? _______ minutes

    What time of day do you usually nap? Morning / Afternoon / Evening

    How many naps do you usually take per day? _______

    How many naps do you usually take per week? _______

Insomnia questions

32. Do you usually have difficulty falling asleep at the beginning of the sleep period? ▢ Yes ▢ No
33. Are you bothered by awakenings that occur during the night (after you've fallen asleep)? ▢ Yes ▢ No
34. Do you wake up too early and find that you can't return to sleep? ▢ Yes ▢ No
35. If you answered yes to any of the above, are you bothered by the problem? ▢ Yes ▢ No
36. Does difficulty falling asleep or staying asleep interfere with your daytime functioning? ▢ Yes ▢ No
37. Do you tend to "watch the clock" before or during your sleep? ▢ Yes ▢ No

Sleep quality
38. Are you bothered by restless or poor quality sleep? ❑ Yes ❑ No
39. Do you feel that you sleep too “lightly?” ❑ Yes ❑ No
40. Do you feel that your sleep is not restful, no matter how much sleep you get? ❑ Yes ❑ No

Snoring and breathing abnormality during sleep
41. Do you snore? ❑ Yes ❑ No
42. Have you awakened yourself or someone else with your snoring sounds? ❑ Yes ❑ No
43. Is snoring a source of distress in your marriage or other significant relationship? ❑ Yes ❑ No
44. Has anyone ever told you that you have difficulty breathing or that you stop breathing during sleep? ❑ Yes ❑ No
45. Do you ever awaken with the sensation of shortness of breath? ❑ Yes ❑ No
46. Do you ever awaken gasping, choking, or “gasping for air?” ❑ Yes ❑ No
47. Do you often awaken with a dry mouth or sore throat? ❑ Yes ❑ No
48. Do you ever awaken feeling disoriented or confused? ❑ Yes ❑ No
49. Do you ever awaken with headaches? ❑ Yes ❑ No
50. Do you use the restroom frequently at night? ❑ Yes ❑ No
51. Do you experience “acid reflux,” “acid indigestion,”? ❑ Yes ❑ No
52. Have you had surgery for snoring or sleep apnea? ❑ Yes ❑ No

If yes, please give name and when the surgery was done ______________________________

53. Have you been treated for snoring or sleep apnea with a dental device? ❑ Yes ❑ No
54. Have you been treated for snoring or sleep apnea with nasal CPAP, BiPAP, or Autopap? ❑ Yes ❑ No

Narcolepsy questionnaire
55. Have you ever experienced “sleep attacks” (sudden, irresistible urge to sleep)? ❑ Yes ❑ No
56. Upon falling asleep or waking up have you ever had the experience of seeing things or hearing things that were not really there? ❑ Yes ❑ No
57. Upon falling asleep or waking up have you ever had the experience of being unable to move your arms or legs, even if you try? ❑ Yes ❑ No
58. Have you ever done things during the day without having awareness of your actions? ❑ Yes ❑ No
59. Have you ever had a seizure? ❑ Yes ❑ No
60. Have you ever experienced sudden muscle weakness while awake? (in mild conditions this could be experienced as a weak grip, or leg or arm weakness; in severe conditions, one’s legs might buckle and the person might fall to the floor) ❑ Yes ❑ No

If yes, was this brought on by an intense emotion? ❑ Yes ❑ No

61. Do you start dreaming right after you fall asleep? ❑ Yes ❑ No

Limb movements or sleep related movements
62. Do you experience painful or unusual sensations of your legs while at rest, especially in the evening? ❑ Yes ❑ No
63. Do painful or unusual sensations of your legs interfere with your ability to fall asleep? ❑ Yes ❑ No
64. Do you experience painful or unusual sensation of your legs that awaken you, or that prevent you from returning to sleep if you wake up during your sleep period? ❑ Yes ❑ No
65. If you answered yes to any of the above items, does walking or massage seem to relieve the discomfort in your legs? ❑ Yes ❑ No
66. Do you ever experience "twitching" or "jerking" of your feet or legs while asleep? ❑ Yes ❑ No
67. Do your leg movements disturb your bed partner? ❑ Yes ❑ No

Shift work questions
68. If employed, what are your usual work hours? Start shift:_____ AM / PM End: _____ AM / PM
69. Are you a shift worker (evenings, nights, or rotating shifts)? ❑ Yes ❑ No
70. Do you frequently suffer from jet lag? ❑ Yes ❑ No
71. Do you find that you typically fall asleep **earlier** than desired and awaken **earlier** than desired? ❑ Yes ❑ No
72. Do you find that you typically fall asleep **later** than desired and awaken **later** than desired? ❑ Yes ❑ No

Abnormal behaviors in sleep

73. Please indicate if you have experienced the following symptoms at any time. Please note the age that symptoms began and your age when they stopped. Place a checkmark in the column at the right to indicate an ongoing problem.

Problem Behavior	Check "yes" if past or current problem	Frequency/ week	Age when symptoms began	If stopped, age when last occurred	Ongoing problem?
Sleepwalking	❑ Yes ❑ No				❑ Yes ❑ No
Sleepwalking associated with "night eating"	❑ Yes ❑ No				❑ Yes ❑ No
Sleepwalking associated with injury to self/others	❑ Yes ❑ No				❑ Yes ❑ No
Nightmares	❑ Yes ❑ No				❑ Yes ❑ No
Night Terrors	❑ Yes ❑ No				❑ Yes ❑ No
Bed Wetting	❑ Yes ❑ No				❑ Yes ❑ No
Sudden unusual movements during sleep	❑ Yes ❑ No				❑ Yes ❑ No
Sleep talking	❑ Yes ❑ No				❑ Yes ❑ No
Other (describe):	❑ Yes ❑ No				❑ Yes ❑ No

Sleep History

74. Have you ever been diagnosed with a sleep disorder ❑ Yes ❑ No

If yes, please list

____

75. Have you ever had a sleep study ❑ Yes ❑ No

If yes, please list where and when

____

What was the result of the study?

____

Medical History
76. Have you now, or have you ever in the past, received treatment for high blood pressure? ❑ Yes ❑ No
77. Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? ❑ Yes ❑ No
78. Have you ever suffered a stroke? ❑ Yes ❑ No
79. Have you ever suffered a heart attack? ❑ Yes ❑ No
80. Have you been told that you have GERD (gastroesophageal reflux disease), acid indigestion, or dyspepsia? ❑ Yes ❑ No
81. Have you ever been hospitalized for any reason? ❑ Yes ❑ No
If yes, why?
____
82. Have you ever had surgery? ❑ Yes ❑ No
If yes, why?
____
83. Have you ever had a serious injury? ❑ Yes ❑ No
If yes, why?
____

Review of systems
84.
General - □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness
Skin - □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes
Head - □ Headache □ Head injury
Ears - □ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage
Eyes - □ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision
Nose - □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain
Throat - □ Teeth □ Gums □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness □ Thrush □ Non-healing sores
Neck - □ Lumps □ Swollen glands □ Pain □ Stiffness
Breasts - □ Lumps □ Pain □ Discharge
Respiratory - □ Cough □ Sputum □ Shortness of breath (dyspnea) □ Wheezing
Cardiovascular - □ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity (dyspnea) □ Difficulty breathing lying down (orthopnea) □ Swelling (edema)
Gastrointestinal - □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea
Urinary - □ Frequency □ Urgency □ Burning or pain □ Incontinence □ Change in urinary strength
Genital Male - □ Loss of libido □ Erectile dysfunction □ STD's
Female - □ Hot flashes □ Vaginal discharge
Musculoskeletal - □ Muscle or joint pain
Neurologic - □ Dizziness □ Fainting □ Seizures
Psychiatric - □ Anxiety □ Depression □ Memory loss □ Stress

Medications

85. Please list all prescription and over-the-counter medications that you currently use.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

Intake questionnaire and social history

86. For each beverage listed, indicate the average number of ounces you drink per day:

    _____ Regular coffee
    _____ Regular tea
    _____ Cola

87. Do you usually drink caffeinated beverages (coffee, tea, cola) within 6 hours before bedtime? ❑ Yes ❑ No
88. Do you drink caffeinated beverages during the day to help you stay awake? ❑ Yes ❑ No
89. On average, do you consume more than 5 alcoholic drinks per day? ❑ Yes ❑ No
90. On average, do you consume more than 15 alcoholic drinks per week? ❑ Yes ❑ No
91. Do you drink alcohol (beer, wine, or hard liquor) shortly before bedtime? ❑ Yes ❑ No
92. Do you use alcohol to help you fall asleep? ❑ Yes ❑ No
93. Do you smoke cigarettes? ❑ Yes ❑ No

    If yes, how many cigarettes do you smoke per day? ______
    Do you smoke just before bed, or if you happen to awaken during your sleep period? ______

94. Do you smoke cigars or a pipe? ❑ Yes ❑ No
95. Do you use any illicit drugs (e.g., marijuana, cocaine, crack)? ❑ Yes ❑ No
96. Do you use any illicit drugs to help you fall asleep or stay asleep, or stay awake? ❑ Yes ❑ No

Family history

97. Father's age: _____ If deceased, what was the year and cause of death? ____
98. Mother's age: _____ If deceased, what was the year and cause of death? ____
99. Number of siblings: _____ Ages of your children: __________________

100. Does anyone in your family have any sleep problems? ❑ Yes ❑ No

If so, briefly describe and give their relationship to you:

____

101. Does anyone in your family have a history of serious medical or psychiatric problems? ❑ Yes ❑ No

If so, what is their problem and what is their relationship to you?

____