Sleep-Wake Disorders Center of Havasu
Diagnostic and Treatment Specialists
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This information is protected under HIPPA
(Please complete this questionnaire and bring it with you to your appointment)

Name _____ E-mail address _____Date ___/___/___

Phone: Prim. _____Second: _____

Age: _____DOB: ____/ ____/ _____ Sex: M / F Ht: _____ Wt: _____ lbs Collar Size: _____

Prim. Address: _____ Second: _____
(Number & Street) (Number & Street)
_____ _____
(City) (State) (Zip) (City) (State) (Zip)
Referring Physician: _____ Phone: _____

How did you hear about us? □ Doctor □ Friend □ Newspaper □ Internet □ Radio

General Information

1) Occupation _____
   a) Do you have regular hours? Yes □ No □
2) Do you have a regular bed partner? Yes □ No □
3) What is your sleep problem or reason you have come to the Sleep Disorders Consultation or Study? _____
4) In general, into which categories below would your sleep problem best fit?
   a) □ Snoring
   b) □ Excessive Daytime Sleepiness
   c) □ Fatigue
   d) □ Difficulty getting to sleep or staying a sleep
   e) □ Abnormal or Unusual Behavior During Sleep
   f) Other_____
5) How long has this problem been present? _____ months / years
6) Have you had a sleep problem diagnosed in the past? Yes □ No □
   a) If yes, what was the problem? _____
   b) Where was the diagnosis made? _____
   c) What treatment(s) was (were) tried? _____
   d) What treatment helped? _____

Sleep Habits

7) Usual Sleep period
   a) Bed time (attempt to go to sleep)? _____ am/pm ---- Get out of Bed? _____ am/pm
8) If you could set your own schedule, at what time would you
   a) Go to bed? _____am / pm --- At what time would you get out of Bed? _____am / pm
9) How many hours of sleep do you think you usually get? _____ hours
10) Do you keep a fairly regular sleep/wake schedule? Yes □ No □
11) What is the average number of minutes it takes you to fall asleep at night? _____ minutes
12) Do you often awaken during the night? Yes □ No □
   a) If yes, what is the typical number of times per night you wake up? ____
   b) If yes, what awakens you?_____
13) After a typical night's sleep, how often do you feel restored and refreshed?
   a) □ Daily
   b) □Weekly
   c) □1-3 times per month
   d) □ Never

EDS

14) Do you feel excessively sleepy in the daytime? Yes □ No □
    a) How long? _____ months / years
15) Do feel that you can sleep 12 hours or more at a time. Yes □ No □
16) Have you actually fallen asleep while driving a car in the last 12 months? Yes □ No □
    a) How many times? _____
    b) How many near miss accidents because of drowsiness or sleepiness have you had in the past 12 months? _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, 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 affected you:

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

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of doze 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Sitting, inactive, in a public place (theater, meeting, etc.)	
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 lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Watching TV	

OSA

17) Do you snore? Never □ Occasionally □ Frequently □ Always Please circle "loudness" rating below:
    a) 0 1 2 3 4 5 6 7 8 9 10 (very loud & disturbing)
18) Does position affect your snoring? Yes □ No □
    Which position do you snore most loudly?
    a) □ Back
    b) □ Side
19) Do you wake up coughing? Yes □ No □
    a) □ Daily
    b) □ Weekly
    c) □ 1-3 times per month
20) Do you wake up choking? Yes □ No □
    a) □ Daily
    b) □ Weekly
    c) □ 1-3 times per month
21) Has anyone told you that you stop breathing in your sleep? Yes □ No □
    a) □ Daily
    b) □ Weekly
    c) □ 1-3 per month
22) Do you wake up with your heart beating irregularly? Yes □ No □
    a) □ Daily
    b) □ Weekly
    c) □ 1-3 per month
23) Do you wake up with dry mouth/sore throat/headache? Yes □ No □
    a) □ Daily
    b) □ Weekly
    c) □ 1-3 per month

Weight

24) Have you experienced any weight gain? Yes □ No □
    a) How much weight have you gained? _____ lbs

b) What was your weight 1 year ago _____ lbs
c) What was your weight 5 years ago _____ lbs

25) Do you feel your sleepiness is associated with weight gain? Yes □ No □
26) Have you attempted to diet Yes □ No □

Narcolepsy

27) Do you dream during your naps? Yes □ No □
a) □ Daily
b) □ Weekly
c) □ 1-3 per month
28) Have you ever felt sudden muscle weakness when you laughed, got angry, or surprised? Yes □ No □
a) Please describe: _____
29) Have you ever been unable to move your body just as you were falling asleep or waking up? Yes □ No □
a) Please describe: _____
30) Have you ever had any visual hallucinations or exceptionally vivid dreams just as you were falling asleep or waking up? Yes □ No □
a) Please describe: _____

Medical Hhistory

31) Do you currently have or have you ever been diagnosed with.

a)	High Blood Pressure	Yes □ No □	Please list other conditions not listed
b)	Heart Disease	Yes □ No □	_____
c)	Lung Disease	Yes □ No □	
d)	Kidney Disease	Yes □ No □	_____
e)	Diabetes	Yes □ No □	
f)	Arthritis	Yes □ No □	_____
g)	Stroke	Yes □ No □	
h)	Seizures	Yes □ No □	_____
i)	Thyroid Disease	Yes □ No □	
j)	Depression	Yes □ No □	_____
k)	Panic/Anxiety Disorder	Yes □ No □	

SLEEP HYGIENE

32) Do you nap during the day? Yes □ No □
a) How many naps per work day _____ Average length of nap? _____ hours/minutes
b) How many naps per weekend day _____ Average length of nap? _____ hours/minutes
c) Are you refreshed by your naps? Yes □ No □
33) Do you: read / watch TV /worry / smoke / write / eat / in bed? Yes □ No □
34) How many days a week do you exercise? _____

MEDICA TIONS Please list below the name and dose of all medications you are taking (including non-prescription medicines)

Medication Name	Dosage	Reason

INSOMNIA

Answer the following questions assuming "night" means your major sleep time:

35) Do you often have trouble getting to sleep at night? Yes □ No □
36) Do you have periods when you are awake and can't get back to sleep? Yes □ No □
   a) How long are you awake over the night when added together? _____
37) Does waking too early and not being able to get back to sleep bother you? Yes □ No □
   a) How many nights a week do you have a sleep problem? _____
38) Do you frequently check the clock when you are unable to sleep? Yes □ No □
39) Has your mood, memory or thought process recently changed? Yes □ No □
40) Have you noticed a decrease in sexual function or interest? Yes □ No □
41) In the last year, has depression, anxiety or stress interfered with your sleep? Yes □ No □
42) If you had the opportunity, could you nap during the day? Yes □ No □

MOVEMENT

43) Are your bed covers extremely messy when you wake up? Yes □ No □
44) Do you wake yourself by kicking your legs during the night? Yes □ No □
45) Has your bed partner ever complained of your leg kicking during the night? Yes □ No □
46) Do you regularly experience a restless or uncomfortable sensation in your legs that can be relieved by movement Yes □ No □

HABIT HISTORY

47) Have you ever smoked cigarettes? Yes □ No □
48) Years of smoking? _____
49) Do you currently smoke? Yes □ No □
50) Estimated average packs of cigarettes per day: _____ packs
51) On average, I drink: _____ ounces of caffeinated beverages per day.
52) Do you smoke marijuana or take any other mood-altering illicit drugs? Yes □ No □
   a) _____
53) Do you currently drink alcohol? Yes □ No □
   a) On the average, how many drinks do you have? _____ per day
   b) Approximate time of these drinks? _____ am/pm
54) Do you have any other comments regarding your sleep that was not addressed in this questionnaire?

_____

_____