Advanced Sleep & Neurodiagnostics
of MMG

525 North Keene Street, Suite 301, Columbia, MO 65201

Sleep Questionnaire

Name: ______________________________ **Date:** ______________

Please answer all questions as best as you can. If you feel you need to write more to clarify an answer please do so (attach additional pages if necessary). Your sleep history can assist the sleep physician in knowing more about your sleep history and habits and will be evaluated in conjunction with the information from your polysomnogram ("sleep study").

Height: ______ Weight: _______ Neck Circumference: ________ (inches)

1. I am having a sleep study because of: (Check all that apply.)

   □ Excessive fatigue and/or sleepiness.

   □ Snoring.

   □ Others have seen me stop breathing while sleeping.

   □ Difficulty going to sleep.

   □ Difficulty staying asleep.

   □ Difficulty waking up.

   □ Excessive movement while sleeping.

   □ I do not know why/Unknown.

   □ Waking up tired.

   □ Falling asleep during times I am usually awake.

   □ Having difficulty concentrating due to sleepiness.

   □ Worrying about my sleep.

   □ Other (please specify, e.g., morning headaches, etc.): ______________________________

   ____

2. How long have you had problems with your sleep? ______________________________

3. Do you maintain a normal sleep schedule? (yes / no)

   If so, what are your usual hours? ______________ On days off? (if applicable) ______________

4. Do you awaken in the middle of your sleep period? (yes / no)

   If so, how many times and for how long are you typically awake each time? ________________

5. Do you take naps? (yes / no) If so, how often, and how long are your naps typically? ________________

□ 5-15 minutes □ Up to 30 minutes □ 30 minutes-1 hour □ 1-2 hours □ 2-3 hours □ Over 3 hours

6. How long does it usually take you to go to sleep? ____

7. Do you use any sleep aids? (yes / no) If so, please note name and dose: __________________________

8. On a typical day, how many caffeinated beverages do you consume? ________________________________

(if applicable) ______ mg caffeine-containing drugs (e.g., Vivarin, No Doz, Excedrin, Midol Complete)

Do you consume caffeine within 2 hours of bedtime? (yes / no) If so, how much? _________________

9. On a typical day, how many alcoholic beverages do you consume? _________________________________

Do you consume alcohol within 2 hours of bedtime? (yes / no) If so, how much? __________________

10. Do you use tobacco products? (yes / no) If so, what type and how much? ________________________

11. Do you regularly use any illegal drugs? (yes / no) If so, what, how much, and how often? ____________

____

12. Do you exercise regularly? (yes / no)If so, how often? ____

13. Is there a television, computer, or other electronic devices present in the room where you sleep? (yes / no)

*** Please have your bed partner or another person who has seen you sleep answer the following:**

14. How often do you see this person sleep? ____

15. What have you witnessed this person do while asleep? (Check all that apply)

□ Snore (how loudly? ____)

□ Make choking or snarling noises.

□ Stop breathing.

□ Move excessively (please describe: ____)

□ Grind teeth.

□ Sleepwalk.

□ Sleep talk or yell/scream while asleep.

□ Wet the bed.

16. If applicable, please describe anything else that you have witnessed this person do while asleep. _________

____

17. Have you seen this person fall asleep during potentially dangerous situations (such as while driving)? (yes / no)

If so, please describe: ____

Please check any current medical problems and history. Information received from your doctor may not be complete or the most recent clinic visit's information.

□ Hypertension (high blood pressure)	□ Stroke (TIA, aneurysm)	□ COPD/emphysema
□ Congestive heart failure (CHF)	□ Coronary artery disease (CAD)	□ Heart attack
□ Anxiety	□ Depression	□ Other mood disorder
□ Pacemaker	□ Asthma	□ Acid reflux
□ Anemia	□ Seizures/epilepsy	□ Headaches
□ Allergic rhinitis	□ Dementia	□ Hyperlipidemia
□ Cancer (type: ________________________)	□ Tonsillectomy	□ Septoplasty
□ Other sinus/throat surgery (____________)	□ Hypothyroidism	□ Hyperthyroidism
□ Neuropathy	□ Parkinson's disease	□ Diabetes
□ Restless legs syndrome	□ Periodic limb movements in sleep	□ Nightmares
□ Night terrors	□ Neuromuscular disease (e.g., ALS)	□ Blackouts

Please list any other medical/surgical history: ____

____

Please add any additional information about your sleep: ______________________________________

____

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Epworth Sleepiness Scale

Always Tired? Can't Focus? Having Trouble Staying Awake? **Find out now if your sleepiness is excessive.**

It's easy. **The Epworth Sleepiness Scale (ESS)** has 8 routine situations that you rate on a scale from 0 to 3 based on your likelihood of dozing off or fall asleep in each situation. Write the number that corresponds with your answer for each situation in the chance of dozing box.

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

Situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	My score
Sitting and reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place – for example, a theater or meeting	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3	
In a car, while stopped in traffic	0	1	2	3	
				Total score:	

BDI-II Scale

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully circle the number (0, 1, 2, or 3) next to the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. Sadness
0. I do not feel sad.
1. I feel sad much of the time.
2. I am sad all the time.
3. I am so sad or unhappy that I cannot stand it.

2. Pessimism
0. I am not discouraged about my future.
1. I feel more discouraged about my future than I used to be.
2. I do not expect things to work out for me.
3. I feel my future is hopeless and will only get worse.

3. Past Failure
0. I do not feel like a failure.
1. I have failed more than I should have.
2. As I look back I see a lot of failures.
3. I feel I am a total failure as a person.

4. Loss of Pleasure
0. I get as much pleasure as I ever did from the things I enjoy.
1. I do not enjoy things as much as I used to.
2. I get very little pleasure from the things I used to enjoy.
3. I cannot get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0. I do not feel particularly guilty.
1. I feel guilty over many things I have done or should have done.
2. I feel quite guilty most of the time.
3. I feel guilty all of the time.

6. Punishment Feelings
0. I do not feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self-Dislike
0. I feel the same about myself as ever.
1. I have lost confidence in myself.
2. I am disappointed with myself.
3. I dislike myself.

8. Self-Criticalness
0. I do not criticize or blame myself more than usual.
1. I am more critical of myself than I used to be.
2. I criticize myself for all of my faults.
3. I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0. I do not have any thoughts of killing myself.
1. I have thoughts of killing myself but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

10. Crying
0. I do not cry any more than I used to.
1. I cry more than I used to.
2. I cry over every little thing.
3. I feel like crying but I cannot.

11. Agitation
0. I am no more restless or wound up than usual.
1. I feel more restless or wound up than usual.
2. I am so restless or agitated that it is hard to stay still.
3. I am so restless or agitated that I have to keep moving or doing something.

Subtotal #s 1-11: ________________

12. Loss of Interest

0. I have not lost interest in other people or activities.
1. I am less interested in other people or things than before.
2. I have lost most of my interest in other people or things.
3. It is hard to get interested in anything.

13. Indecisiveness

0. I make decisions about as well as ever.
1. I find it more difficult to make decisions than usual.
2. I have much greater difficulty making decisions than I used to.
3. I have trouble making any decisions.

14. Worthlessness

0. I do not feel I am worthless.
1. I do not consider myself as worthwhile and useful as I used to.
2. I feel more worthless as compared to other people.
3. I feel utterly worthless.

15. Loss of Energy

0. I have as much energy as ever.
1. I have less energy than I used to have.
2. I do not have enough energy to do very much.
3. I do not have enough energy to do anything.

16. Changes in Sleeping Pattern

- 0. I have not experienced any change in my sleeping pattern.
- 1a. I sleep somewhat more than usual.
- 1b. I sleep somewhat less than usual.
- 2a. I sleep a lot more than usual
- 2b. I sleep a lot less than usual.
- 3a. I sleep most of the day.
- 3b. I wake up 1-2 hours early and cannot get back to sleep.

17. Irritability

0. I am no more irritable than usual.
1. I am more irritable than usual.
2. I am much more irritable than usual.
3. I am irritable all the time.

18. Changes in Appetite

- 0. I have not experienced any changes in my appetite.
- 1a. My appetite is somewhat less than usual.
- 1b. My appetite is somewhat greater than usual.
- 2a. My appetite is much less than before.
- 2b. My appetite is much greater than usual.
- 3a. I have no appetite at all.
- 3b. I crave food all the time.

19. Concentration Difficulty

0. I can concentrate as well as ever.
1. I cannot concentrate as well as usual.
2. It is hard to keep my mind on anything for very long.
3. I find I cannot concentrate on anything.

20. Tiredness or Fatigue

0. I am no more tired or fatigued than usual.
1. I get more tired or fatigued more easily than usual.
2. I am too tired or fatigued to do many of the things I used to do.
3. I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely.

Subtotal #s 1-11 (from last page): _______________

Subtotal #s 12-21 (this page): __________________

Total Score #s 1-21 (both pages): _______________

Medication List

Name: ______________________________ **Date of Birth**: _______________ **Date**: ___________

Please list any medications that you take including their dosages. Include over-the-counter, dietary and herbal supplements as well. We ask for an update from you directly since there are many times that patients have medication changes in-between their last physician visit and the time of the sleep study. Attach pages if necessary.

Medication Name/Dose	Medication Name/Dose