



Name Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Height: _____ Weight: _____ Neck Size (if known) _____

Occupation: _____ Shift: _____

Primary Physician: _____ Referring Physician (if different): _____

How would you describe your sleep problem: _____

How Long have you had this problem? _____

Have you had any previous evaluations, examinations, or treatment for your sleep problems? Y N

If yes, what? _____

Do you smoke: Y N How much? _____

Do you drink alcohol? Y N How much? _____

Do you drink caffeinated beverages? (Coffee/Tea/Soda/Energy Drinks)? Y N How many per Day? _____

Do you feel refreshed when you get out of bed in the mornings? Y N

Do you take intentional naps during the day? Y N Sometimes How many per day? _____

How long is your nap? _____ Is the nap refreshing? Y N

After deciding to go to sleep:

What time do you usually go to bed? _____ am pm

Do you usually have difficulty falling asleep? Y N

About waking up:

What time do you get up? _____ am pm

How do you typically wake? Spontaneously Alarm clock Other

Check any of the following techniques you use to help you sleep (if any):

<input type="checkbox"/>	Medication (prescription of over-the counter)	<input type="checkbox"/>	Hot bath
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	Watching TV	<input type="checkbox"/>	Reading
<input type="checkbox"/>	Listening to CD or Radio	<input type="checkbox"/>	Food, special drinks (non-alcoholic)
<input type="checkbox"/>	Relaxation techniques (deep breathing, etc)	<input type="checkbox"/>	Mental imagery (counting sheep, etc)
<input type="checkbox"/>	Biofeedback (self-hypnosis, tapes, etc)	<input type="checkbox"/>	

Check any of the following that you experience or have been told that you experience during your sleep:

<input checked="" type="checkbox"/>		For How Long
<input type="checkbox"/>	Jerk, kick or twitch	
<input type="checkbox"/>	Snore	
<input type="checkbox"/>	Breathing pauses or stop periodically	
<input type="checkbox"/>	Wake choking or gasping	
<input type="checkbox"/>	Walk or talk while asleep	
<input type="checkbox"/>	Grinding of teeth	
<input type="checkbox"/>	Nightmares	
<input type="checkbox"/>	Feel heart pounding or skipping	
<input type="checkbox"/>	Asthma or shortness of breath	
<input type="checkbox"/>	Excessive sweating	
<input type="checkbox"/>	Have frequent heartburn	
<input type="checkbox"/>	Sinus/nasal congestion	
<input type="checkbox"/>	Frequent waking to urinate	
<input type="checkbox"/>	Unusual behavior (thrashing, hitting bed partner, etc)	
<input type="checkbox"/>	Wake too early and have trouble going back to bed	
<input type="checkbox"/>	Have a difficult time waking up (groggy)	
<input type="checkbox"/>	Feel unable to move on awaking	
<input type="checkbox"/>	Wake up with a headache	
<input type="checkbox"/>	Wake with a dry mouth and/or throat.	
<input type="checkbox"/>	Recent problems with memory and/or concentration	
<input type="checkbox"/>	Recent changes in mood (such as: mood swings, increased irritability)	
<input type="checkbox"/>	Are under increased stress or pressure	
<input type="checkbox"/>	Males Only. Having problems with sexual relations/functioning (such as erectile dysfunction)	
<input type="checkbox"/>	Suffer from depression and/or anxiety	

How often does the following bother you?

	Never	Sometimes	Often	Always
Feel sleepy or fell asleep while driving				
Feel sleepy or fell asleep at work or school				
Experience periods of unintentional sleep				
Experience periods of muscle weakness or loss of muscle control with laughter, excitement, or sadness				
Experience vivid dreams when falling asleep or waking from sleep				

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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.

SITUATION	CHANCE OF DOZING	
Sitting and reading _____	→	Use the following scale to choose the most appropriate number of each situation: 0 = would never 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing
Watching TV _____	→	
Sitting, inactive in a public place (ex: theater or meeting) _____	→	
As a passenger in a car for an hour without a break _____	→	
Lying down to rest in afternoon when circumstances permit _____	→	
Sitting and talking to someone _____	→	
Sitting quietly after a lunch without alcohol _____	→	
In a car, while stopped for a few minutes in traffic _____	→	
TOTAL		

