Family Sleep Diagnostics

Saving Lives and Marriages

Sleep Assessment

Patient Name ____ DOB ___________________ Date ___________

The following questions will help us to obtain an understanding of your sleeping problems. It is extremely important that you answer these questions as completely as possible. There are some questions that your bedpartner or room-mate can be helpful with, such as snoring.
Do not spend too much time on these questions: your first impression is the best answer in most cases. Answer all questions by considering the past six months, unless otherwise specified. If you are engaged in shiftwork or other unusual sleep / wake schedule, refer to 'Daytime' as the times you would normally be awake. and 'Nighttime' when you would be sleeping.

Do you feel that you:

1. Get too little sleep at night? ❏ Yes ❏ No
2. Get too much sleep at night ❏ Yes ❏ No

How much of a problem do you have?	**Not at all None**	**Slight Few Times**	**Moderate Sometimes**	**Often**	**Severe Always**
3. While sitting and reading?	❏	❏	❏	❏	❏
4. While watching TV?	❏	❏	❏	❏	❏
5. While sitting or inactive in a public place?	❏	❏	❏	❏	❏
6. As a passenger in a car for an hour, w/o a break?	❏	❏	❏	❏	❏
7. Lying down to rest in the afternoon?	❏	❏	❏	❏	❏

8. On a weekday, what time do you usually...
   Go to bed ___________ am/pm
   Do you normally take naps: ❏ Yes ❏ No
   If yes, how many times per day? ____________ What time (s)? ____________
   How long does a typical nap last? ___________ minutes / hours
9. Do you watch TV or read in bed before going to sleep? ❏ Yes ❏ No
10. Do you use sleeping aids or medicine? ❏ Yes ❏ No
    If yes, please list: ____ How often do you use it? _________
11. How long are you in bed before deciding to go to sleep? ______________ hours ____________ minutes
12. How long does it take you to fall asleep after you have decided to? ______________ hours ____________ minutes
13. How many hours of sleep do you get in a typical night? ______________ hours ____________ minutes
14. How many times do you wake up in a typical night? ______________ hours ____________ minutes
15. How long is a typical wake time? ______________ hours ____________ minutes
16. If you do awaken during your sleep, which part(s) of the night is it likely to happen?
    ____________ First third ____________ Second third ____________ Last third
17. How many times do you get out of bed in a typical night? ______________ times
18. How long is the typical time out of bed during the night? ______________ hours ____________ minutes

When falling asleep, how often do you:	**Not at all None**	**Slight Few Times**	**Moderate Sometimes**	**Often**	**Severe Always**
19. Have thoughts racing through your mind	❏	❏	❏	❏	❏
20. Feel sad or depressed	❏	❏	❏	❏	❏
21. Have anxiety, or worry about things	❏	❏	❏	❏	❏
22. Feel muscular tension	❏	❏	❏	❏	❏
23. Feel afraid of not being able to go to sleep	❏	❏	❏	❏	❏

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When falling asleep, how often do you:	**Not at all None**	**Slight Few Times**	**Moderate Sometimes**	**Often**	**Severe Always**
24. Feel unable to move or paralyzed	❑	❑	❑	❑	❑
25. Notice parts of your body startle or jerk	❑	❑	❑	❑	❑
26. Experience restlessness in your legs (crawling or aching, unable to keep your legs still)	❑	❑	❑	❑	❑
27. Experience vivid, dreamlike scenes or hallucinations even though you are awake	❑	❑	❑	❑	❑
28. Experience pain or discomfort	❑	❑	❑	❑	❑
During the night, how often do you:					
29. Sleep with someone else in your room	❑	❑	❑	❑	❑
30. Sleep with someone else in your bed	❑	❑	❑	❑	❑
31. Sleep on a special surface	❑	❑	❑	❑	❑
32. Have restless, disturbed sleep	❑	❑	❑	❑	❑
33. Disturb the sleep of your bed partner	❑	❑	❑	❑	❑
34. Provide assistance to someone or something else during the night	❑	❑	❑	❑	❑
35. Have nasal congestion	❑	❑	❑	❑	❑
36. Use nasal spray or other medication to deal with nasal congestion	❑	❑	❑	❑	❑
37. Snore	❑	❑	❑	❑	❑
38. Hold your breathe or stop breathing	❑	❑	❑	❑	❑
39. Wake up gasping for air or feeling you can't breathe	❑	❑	❑	❑	❑
40. Wake with a choking sensation	❑	❑	❑	❑	❑
41. Have some other breathing problem during sleep	❑	❑	❑	❑	❑
42. Sweat excessively	❑	❑	❑	❑	❑
43. Sleep walk	❑	❑	❑	❑	❑
44. Sleep talk	❑	❑	❑	❑	❑
45. Grind your teeth	❑	❑	❑	❑	❑
46. Have leg twitching or jerking during the sleep	❑	❑	❑	❑	❑
47. Have other unusual movements during sleep	❑	❑	❑	❑	❑
48. Eat during the night after you go to sleep	❑	❑	❑	❑	❑

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During the night, how often is your sleep disturbed because of:	**Not at all None**	**Slight Few Times**	**Moderate Sometimes**	**Often**	**Severe Always**
49. Stomach or abdominal pains	❏	❏	❏	❏	❏
50. Leg cramps	❏	❏	❏	❏	❏
51. Parasthesia (pins and needles sensation) in your arms or legs	❏	❏	❏	❏	❏
52. Itching sensations	❏	❏	❏	❏	❏
53. Feeling short of breath in a flat position	❏	❏	❏	❏	❏
54. 'Gas' in your stomach, or indigestion	❏	❏	❏	❏	❏
55. Awakening with regurgitation, or burning in your throat	❏	❏	❏	❏	❏
56. Hunger	❏	❏	❏	❏	❏
57. Thirst	❏	❏	❏	❏	❏
58. Awakening with the urgent need to urinate	❏	❏	❏	❏	❏
59. Intense heart pain (angina)	❏	❏	❏	❏	❏
60. Other chest pains	❏	❏	❏	❏	❏
61. Asthma	❏	❏	❏	❏	❏
62. Persistent coughing	❏	❏	❏	❏	❏
63. How often do you feel extremely alert and energetic all day?	❏	❏	❏	❏	❏

64. How long does it take to "get going" in the morning? __________ minutes

65. How many miles do you drive to work each day? __________ Approximately how may miles per year do you drive? __________

66. On a scale of 1 to 10, with 10 being the worst or most problem, how much does sleepiness affect your: (circle on number)
    Driving performance? 1 2 3 4 5 6 7 8 9 10 Work performance? 1 2 3 4 5 6 7 8 9 10

67. Have you had driving accidents or 'near miss' incidents while driving related to sleepiness? ❏ Yes ❏ No

68. If the answer to number 67 is yes, How many accidents have you had due to sleepiness? __________
    How many near miss incidents have you had due to sleepiness? __________

69. What shift do you normally work? Day / 1st ________ Evening / 2nd ________ Night / 3rd ________ Swing ________

70. How many work related mistakes per year do you have associated with sleepiness? __________ Fatigue? __________

71. How many accidental work injuries per year do you have associated with sleepiness? __________ Fatigue? __________

72. Do you normally work more than 40 hours per week? ❏ Yes ❏ No

Please fax this completed form to 1-800-816-1477 or bring it with you to your first Sleep Study appointment.