The Sleep Institute
Idaho's home for leading-edge sleep care – and a good night's rest

Name: _____
Age: _____
Height____Weight_____
Phone #: _____
Date: _____

Sleep Evaluation

What would you like to improve about your sleep?

1.

2.

3.

Please take the time complete this questionnaire as completely as possible.
The more information we get, the more we can help.

How many years has it been since you felt good, slept well, woke well rested and functioned well all day? _____
What time did you go to bed? _____*AM/PM* How long did it take you to fall asleep? _____minutes/hours
What time did you wake up? _____AM/PM
What Changed in your life to cause your current problems? _____

Yes No Do you feel that no matter how much sleep you get, you don't wake up feeling rested?
Yes No Do you have difficulty getting to sleep?
Yes No Do you have problems because of waking up at night?
Yes No Do you have difficulty waking up in the morning?
Yes No Do you fall asleep when you shouldn't?
Yes No Have you fallen asleep in any dangerous situations?

On a typical night, how many hours do you TRY to sleep? _____
How may hours of sleep do you actually get?_____
____AM/PM What time do you usually go to bed?
____AM/PM What time do you usually get up?
____Min How long does it take you to fall asleep?
Yes No Have you **EVER** had accidents or near-accidents (especially driving a car) because you felt extremely sleepy, had trouble concentrating or had hallucinations? Example: _____
Yes No Have you **EVER** been in unusual, unpleasant, or embarrassing situations because you felt extremely sleepy or were having trouble concentrating? (E.g. fall asleep while on the phone, while talking to people, at meetings, at church, while eating, etc.)
Yes No Have you EVER been told you stop breathing at night?
Yes No Have you EVER been told that you snore?
Do you have headaches in the evening? _____ Night? ____ in the morning? _____
Yes No Do you have nasal obstruction, sinusitis, chronic nasal congestion or nasal discharge during the night or when you awaken? If Yes, What's been tried to help? What's Worked? What hasn't?
Yes No Do you take daytime naps during the usual weekday? What is the longest usual daytime nap? __
Does a daytime nap make you feel: (circle one) ***More Alert*** ***Less Alert*** ***No Change in Alertness***
How many times do you wake up during a typical night's sleep? _____
How many times do you get out of bed? _____Why? _____
How long do you stay out of bed? _____
If you are awake during the night, how long is the typical longest wake (IN BED)? _____
If you are awake during the night, when does it typically occur? (First third of night, second third, or last third)

Please Circle ALL of the following you've ever been told that you have:
High Blood Pressure / Congestive Heart Failure / CHF / Pulmonary Hypertension / Heart Attack
Stroke / Insulin Resistance / Diabetes / Overweight

Yes No Do you move your arms, legs, or body much or have unusual behaviors during sleep?
Explain: _____

Yes No Do you have feelings of aching, restlessness, or "pins and needles" in your legs at rest?

Yes No Do you walk in your sleep? When was the last time? _____

Yes No Have you been told that you grind your teeth during sleep?

Yes No Since you have been an adult, have you wet the bed during sleep?

Yes No Have you eaten food, or smoked cigarettes, or done some other complex activity without full awareness or control (i.e. semi-consciously or unconsciously) during sleep or during partial awakenings

Yes No Do you have frequent, frightening dreams or nightmares?

Yes No Do you move while dreaming as if you are simultaneously trying to carry out the dream?

Yes No Have you been injured, or injured someone else while sleeping?

Yes No Are your dreams frequently action-filled, with the dream characters moving around considerably, being quite physically active, fighting or being chased by people or animals?

Yes No Do you have dream-like mental images or hallucinations when you are not actually asleep, but in the process of falling asleep or as you are waking up in the morning?

Yes No Do you have sudden onset of an overwhelming urge to sleep

Yes No Have you EVER had attacks of sudden physical weakness or paralysis during the day when laughing, angry, or in other emotional situations?

Yes No Do you have vivid dreams during your daytime naps?

Yes No Did your sleep/awake symptoms begin or become worse during adolescence?

Do you wake up suddenly with an unpleasant feeling of fear, panic, or disorientation (confusion)? Yes No

Do you lie awake at night feeling depressed, worried, anxious, tense, fearful, unhappy or disoriented? Yes No

Is your sleep better or worse when you are on vacation? Yes No In what way? _____

Have you always been a "light sleeper?" Yes No

Do things keep you awake that don't keep other people awake? What? _____

Have you had months without insomnia? Yes No

Is your sleep environment Comfortable, Dark, Quiet, pleasant and Safe? If not, Please explain: _____

Yes No Do you have loss of interest in things that used to be of interest (sex, golf, friends, etc…)?

Yes No Do you have feelings of hopelessness or helplessness?

Yes No Have you been interviewed by a psychiatrist or clinical psychologist? Why? _____

Yes No Do you feel that you are living under unusual pressure or stress at the present time?

Yes No Have there been any significant changes in your life in the past year? Explain:
_____

Yes No Do you often feel depressed?

Yes No Do you have crying spells?

Yes No Do you often feel tense worried or anxious?

Yes No Have you EVER attempted suicide or been admitted to a psychiatric hospital unit?

Yes No Have you EVER been physically, sexually or emotionally abused?

Yes No Have you **EVER** used meditation, acupuncture, hypnosis, biofeedback, or relaxation therapy to lower your tension level and help you to sleep?

PAIN:

Yes No Do you have frequent headaches in the evening? _____ night? ____ or in the morning? _____

Yes No Do you have pain during the day? _____

Yes No Does pain interfere with your sleep? _____

Yes No Have you done anything to help the pain? What's worked? _____
What hasn't worked? _____

Yes No Are you bothered by leg cramps or pains in the calf (charley horses) during the night?

EXERCISE:

_____ How many times a week do you exercise or engage in some type of physical activity?

Explain: _____What time of day do you usually exercise? _____

NEUROLOGY:

Yes No Have you **EVER** been treated for meningitis, mononucleosis or encephalitis?

Yes No Have you **EVER** had a convulsion (fit, seizure, epilepsy) at night or during the day? When was Your last seizure? _____

Yes No Have you been knocked unconscious or had any other serious injury to your head? When? _____

Yes No Have you **EVER** "come to" and discovered that you had performed some complex activity (E.g. driving a car, routine work) without remembering it?

Yes No Do you do things that make no sense? (E.g. mixing chocolate with gravy when cooking, writing notes or completing documents which make no sense)

Yes No Do you have hallucinations or dream-like mental images during the day?

RESPIRATORY:

Yes No Do you have nasal obstruction, sinusitis, chronic nasal congestion or nasal discharge during the night or when you awaken? If Yes, What's been tried to help? What's worked? What hasn't?

Yes No Do you use nasal spray or other medication at night to deal with nasal congestion to help you sleep?

Yes No Do you have recurring problems with tonsillitis?

Yes No Do you have shortness of breath or bothersome coughing? Explain: _____

Yes No Do you have chest or lung problems such as asthma, bronchitis, or wheezing? Explain: _____

Yes No Have you gained or lost weight in the last year? How many pounds?

ENDOCRINOLOGY:

NEXT FOUR QUESTIONS ARE FOR WOMEN ONLY

Yes No Do your sleep/awake problems change with the stage of your menstrual cycle?

Yes No Are you pregnant?

Yes No Are you past menopause (change of life)?

Yes No If you are menopausal or post-menopausal, did your sleep change during or after menopause? In what way? _____

SEXUAL FUNCTIONING:

Yes No Do you feel that you are too sleepy to have a satisfactory sex life?

NEXT TWO QUESTIONS ARE FOR MEN ONLY

Yes No Do you have problems obtaining or sustaining a penile erection? Are you being treated? _____

Yes No Do you have problems with ejaculation?

Please List your other health problems and medications:

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

Yes No Have you **EVER** obtained a prescription for any type of medication to help with your sleep?

List medications, tranquilizers or sedatives you are currently taking (or have taken) for your sleep problem:

_____

_____

_____

Yes No Is your sleep and daytime function satisfactory when taking sedatives or tranquilizers?
Yes No Have you **EVER** taken stimulants (Ritalin, amphetamines, weight loss pills)? Do you function satisfactorily during the day when taking stimulants? Yes No

CHILDHOOD SLEEP HISTORY:
Circle any of the following problems you had with your sleep when you were a child:
bed wetting, sleep talking, sleepwalking, nightmares, night terrors screaming in sleep, convulsions during sleep, fear of dark, fear of sleep, grinding teeth, head banging, excessive sleepiness

FAMILY HISTORY:
Yes No Does anyone else in your family has problems with sleep? (This includes breathing problems, snoring, sleep paralysis, insomnia, excessive daytime sleepiness, sleepwalking, night terrors, sudden infant death syndrome, etc.) **Explain:**
Yes No Does anyone in your family have any medical or psychiatric problems? **Explain:**
_____
_____
_____

SOCIAL HISTORY: (leave questions blank that you don't feel comfortable answering)
How would you describe your childhood family?
With whom did you live for most of the time until you were 18 years of age?
How well did you get along with your parents when growing up?
How well did your parents get along with each other?
Who lives with you in your current household (please include pets).

How many times have you been married?_____ How many children have you had? _____
Circle the response that best describes how you and your living partner get along:
Well OK Badly
Circle the highest grade you completed in school: 7 8 9 10 11 12 13 14 15 16 17+
Academic Degrees:
Circle the response that best describes your present work:
Employed Self-employed Laid-off Dismissed from job Retired Unemployed Part-time work Temporary job
Yes No At the present time do you work at more than one job?
_____ How many hours a week do you work now?
What is your present occupation? _____
Yes No is your present occupation satisfying? _____
Briefly describe the best job you have ever had: _____
What is (or was) your parents' occupations? _____
What is (or was) your spouse's occupation? _____
Yes No Are you in danger of losing your job because of your sleep problems? _____
If your sleep/wake complaint is not adequately covered by these questions, list anything else which especially interferes with your sleep or affects your wakefulness.

ALCOHOLIC BEVERAGES-TOBACCO:
_____ How many caffeinated beverages of coffee, tea, or cola do you have in a usual day?
Yes No Do you usually drink coffee, tea, or cola within 2 hours of your bedtime?
Yes No 5 hours of your bedtime?
How much alcohol do you drink daily?
Assuming the following drinks are equivalent: 12 oz. beer, 5 oz. wine, 3 oz. port and 1.5 oz. whiskey, gin, or vodka, then how many drinks do you have in a usual_____Weekday?_____Weekend or Holiday?
Yes No Do you drink alcohol within 2 hours of bedtime?
Yes No Do alcoholic beverages alter or interfere with your sleep?
Yes No Have you **EVER** used alcohol to get to sleep?

Have you **EVER** had the following problems in association with drinking alcoholic beverages?

Yes No Blackouts
Yes No Violent or over-excited behavior
Yes No Automatic behavior (carrying out actions without being aware of what you are doing)
Yes No D.T.'s, shakes, hallucinations
Yes No Arrests for drunken driving
Yes No Family complaints or personal concerns about your drinking
Yes No Late or missed work or appointments
Yes No Detoxification or other treatment
_____ *How much tobacco do you use daily?*

Epworth Sleepiness Scale
Your chance of dozing in the following circumstances

0=Would Never Doze
1=Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

Situation	Chance of Dozing
Sitting and Reading	_____
Watching Television	_____
Sitting, inactive in a public place (i.e. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when the 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***

Is there anything else we should know?

BED-PARTNER QUESTIONNAIRE Name of Patient_____ Date: _____

I have observed this person's sleep:____Never ___Once or Twice ____Often ____Every Night

Check any of the following behaviors that you have observed this person doing while asleep.

Circle those that you consider **severe** problems for this person.

____Light Snoring
____Occasional loud snoring
____Pause in breathing
____Sleep talking
____Bed-wetting
____Awakening with pain
____Getting out of bed not awake
____Becoming very rigid and/or shaking
____Apparently sleeping even if he/she
____Loud snoring
____Choking
____Twitching or kicking of legs
____Grinding teeth
____Sitting up in bed not awake
____Head rocking or banging
____Biting tongue
____Crying out
____Other behaves otherwise

If this person snores, what makes it worse?

___Sleeping on his/her back ___Sleeping on his/her side ___Alcohol ___Fatigue

Describe the sleep behaviors, checked above, in more detail; include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

Has this person ever fallen **asleep** during normal daytime activities or in dangerous situations? Yes No

Explain if yes:

Does this person use sleeping pills? Yes No

If yes, how many pills per week? ___Less than 1/week ___1-3/week ___4-7/week ___7+/week

Do you consider this usage a problem? Yes No Uncertain

Comments:

Does this person drink alcohol? Yes No

If yes, this person usually drinks :(check as many as you believe are appropriate)____Beer ____Wine____Shots of liquor

Please estimate the per week use of:

_____ 12 oz bottled/canned/tap BEER

_____ 6-8 oz Glasses of WINE

_____ 1-1 ½ oz LIQUOR

Please estimate, how much does this person drink in the 3 hours before bed? _____

Do you consider this person's drinking a problem? Yes No Uncertain

Comments:

If this person uses street drugs, please describe both the types and frequency of usage:_____

_____

Do you believe that this person and you share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage? Yes No Uncertain

Comments:_____

_____

Thank you.

Signed:_____Relationship to patient:_____

WE ASK THAT THE BED PARTNER ACCOMPANY THE PATIENT TO THEIR APPOINTMENTS IF AT ALL POSSIBLE TO GET A MORE COMPLETE HISTORY.