WELCOME TO THE NORTHSHORE UNIVERSITY HEALTHSYSTEM SLEEP CENTERS

Prior to your office visit, we request that you complete this questionnaire. It asks questions not only about your sleeping habits and behavior during sleep, but also about other factors that may influence your pattern of sleep and wakefulness. Please answer these questions to the best of your ability. If your find questions that you cannot answer, mark them with a question mark. If possible, have someone familiar with your sleeping habits help you fill out this questionnaire and bring that person along with you to the consultation. It is very helpful for your Sleep Medicine physician to interview someone who has observed your sleeping.

Please bring the completed questionnaire to the Sleep Medicine consultation.

Name: ________________________________ Date______________ Date of birth_________________

Gender: ☐ Male ☐ Female Age: ________ Current occupation__________________________

Height _____feet _____inches Current weight____________ lbs

Reason for office visit____

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Sleep problem____

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How long have you had this problem? ______________ years _______________months

Have you had a sleeping problem diagnosed in the past? ☐ Yes ☐ No

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Do any of the following occur during sleep or affect your sleep (circle all that apply)?

snoring	stop breathing		gasping	shortness of breath	grinding teeth		choking
pain	chest pain	anxiety	heartburn	esophageal reflux	heart slowing	dry mouth	headache
heart racing		leg cramps		leg discomfort	leg movements		pets
bed partner (snoring, movements)				muscular tension	noise	sadness/depression	
awakening to urinate		bed wetting		temperature of room		uncomfortable bed	
unable to fall asleep after awakening				unrefreshing sleep	violent upon being awakened		
difficulty falling sleep		awakening early		difficulty staying asleep		racing thoughts	
unable to move before falling asleep or after awakening		nightmares		vivid dreams		unable to move before falling asleep or after awakening	
walking in sleep		talking in sleep		afraid of not being able to sleep		eating in the night	
Hallucination as falling sleep or awakening					wake up confused		
Screaming, shouting, or acting out dreams			other unusual movements		Injury to self or others during sleep		

Have you experienced any of the following while awake (circle all that apply)?

accidents or near accident due to sleepiness	sudden weakness upon laughter, anger, or surprise		sleep attacks
unintentional naps	discomfort in legs at rest	fatigue	difficulty concentrating

System Review (circle any that apply)

System		Findings
Mood	Normal	Anxious, Depressed, Irritable
Memory	Normal	Short term deficits, Long term deficits
General	None	Fatigue, Night sweats, Fevers, Weight loss, Weight gain
Skin	None	Rashes, Excessive hair loss
Eyes	None	Blurred vision, Double vision, Eye pain, Glaucoma, Decreased acuity, Catarrcacts
Nose	None	Congestion, Blockage, Runny nose
Ears	None	Decreased hearing, Ringing
Mouth & Throat	None	Swallowing difficulty, Dentures, Hoarseness
Cardiovascular	None	Dizziness, Ankle swelling, Chest Pain, Irregular heartbeat, Short of breath
Respiratory	None	Wheezing, Difficulty breathing, Cough
Gastrointestinal	None	Nausea, Pain, Constipation, Decreased appetite, Reflux, Heartburn, Gas, Diarrhea, Blood in stool
Genitourinary	None	Incontinence, Infections, Frequency, Urinary discomfort, Blood in urine, Change in sexual function
Musculoskeletal	None	Joint swelling, Joint pain, Muscle pain, Neck pain, Back pain
Endocrine	None	Thyroid problem, Chills, Flushing, Hot flashes, Excessive sweating
Immune/Allergy	None	Allergies
Hematological	None	Bleeding, Infections, Unexplained Bruising
Neurological	None	Headache, Weakness, Tremors, Tingling, Involuntary movements, Seizures, Paralysis, Numbness, Loss of consciousness

Additional Information ____

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What time do you usually **go to bed** on **weekdays** or days that you work? ____________a.m./p.m.
What time do you usually **get up** on **weekdays** or days that you work? ____________a.m./p.m.
What time do you usually **go to bed** on **weekends** or days you don't work? ____________a.m./p.m.
What time do you usually **get up** on **weekends** or days you don't work? ____________a.m./p.m.
How many hours do you usually sleep on **weekdays** or days that you work? ____________hours
How many hours do you usually sleep on **weekend days**? ____________hours
If you could set your own schedule, what time would you go to bed? ____________a.m./p.m.
what time would you get up? ____________a.m./p.m.
What is an average number of minutes it takes you to fall asleep at night? ____________minutes

How many times do you awaken during sleep times? ___________
Is your sleep disrupted by your bed partner, a child or a pet? ☐ Yes ☐ No
Do you go back to sleep quickly (circle one)? **Usually** **Sometimes** **Rarely** **Never**
What is your favorite position of sleep? ☐ On my side ☐ On my back ☐ On my abdomen

Do you take any medications to induce sleep? ☐ Yes ☐ No

If yes, which one(s)? ____

How many nights in a typical week do you take them? ____________________of 7 nights

Do you take naps (circle one)? Yes / No If yes, what time(s)? __________ for how long? ___________
If yes, how often (circle one)? Daily Almost daily Weekly Monthly
Are you refreshed by your naps? ☐ Yes ☐ No
Are you refreshed by a typical night's sleep? ☐ Yes ☐ No

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 years. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 – no chance of dozing
1 – slight chance of dozing
2 – moderate chance of dozing
3 – high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	_________________
Watching TV	_________________
Sitting inactive in a public place (e.g. 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 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 SCORE	_________________

Do you feel excessively sleepy in the daytime? ☐ Yes ☐ No
Do you feel your sleepiness is caused by any drug you are taking? ☐ Yes ☐ No
Have you heard about the sleep apnea syndrome? ☐ Yes ☐ No
Do you personally know anybody with sleep apnea syndrome? ☐ Yes ☐ No
Have you heard about CPAP, or continuous positive airway pressure as a method to treat sleep apnea syndrome? ☐ Yes ☐ No
If yes, what have you heard about CPAP?
☐ Good things ☐ Unpleasant things ☐ Both good and unpleasant things
Do any members of your family have:
☐ Snoring ☐ Sleep apnea ☐ Restless Legs Syndrome ☐ Sleep walking ☐ Narcolepsy

Past Medical History

Condition	Yes	No	Condition	Yes	No
Anemia/Bleeding Disorders	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Obstructive Sleep Apnea	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Stroke or TIAs	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Hypercholesterolemia	☐ Yes	☐ No	Migraine	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Gastoesophageal reflux	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Allergies If yes, list Allergies:	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No			

Other

Comments: ______________________________

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Past Surgical History

If any, list all Surgeries and their Year

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Medications

If any, list all medications and their doses

1 ______________________________

2 ______________________________

3 ______________________________

4 ______________________________

5 ______________________________

6 ______________________________

7 ______________________________

8 ______________________________

Additional comments regarding your sleep and questions that you would like to have answered: ________