Patient Name: _____ Date:_____

WELCOME TO THE NORTHSHORE UNIVERSITY HEALTHSYSTEM SLEEP CENTERS

To better assess you at the time of service, 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 you find questions that you cannot answer, mark them with a question mark.

Do you currently live: ☐ At home ☐ Nursing home
☐ Assisted living/ retirement home ☐ Religious community

Spouse Name _____
# of Children _____
Years of Education _____

What is the country of origin of your biological father's ancestors? _____

What is the country of origin of your biological mother's ancestors? _____

SYSTEM REVIEW (circle any that apply)

Constitutional ☐ Normal	**Eyes** ☐ Normal	**Gastrointestinal** ☐ Normal	**Endo/Hem/Aller** ☐ Normal
Fever	Blurred vision	Heartburn	Easy bruise/bleed
Chills	Double vision	Nausea	Environmental allergies
Weight loss	Photophobia	Vomiting	Polydipsia (excessive thirst)
Malaise/Fatigue	Eye pain	Abdominal pain	**Neurological** ☐ Normal
Diaphoresis (excessive sweating)	Eye discharge	Diarrhea	Dizziness
Weakness	Eye redness	Constipation	Tingling
Skin ☐ Normal	**Cardiovascular** ☐ Normal	Blood in stool	Tremor
Rash	Chest pain	Melena (black stool)	Sensory change
Itching	Palpitations	**Genitourinary** ☐ Normal	Speech change
HENT ☐ Normal	Orthopnea	Dysuria (painful urination)	Focal weakness
Headaches	Claudication	Urgency	Seizures
Hearing loss	Leg swelling	Frequency	Loss of consciousness
Tinnitus (ringing in the ears)	PND (attacks of severe shortness of breath and coughing at night)	Hematuria (blood in urine)	**Psychiatric** ☐ Normal
Ear pain	**Respiratory** ☐ Normal	Flank pain	Depression
Ear discharge	Cough	**Muskuloskeletal** ☐ Normal	Suicidal ideas
Nosebleeds	Hemoptysis (blood in sputum)	Myalgias (muscle pain)	Substance abuse
Congestion	Sputum production	Neck pain	Hallucinations
Stridor	Shortness of breath	Back pain	Nervous/anxious
Sore throat	Wheezing	Joint pain	Insomnia
		Falls	Memory loss

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

☐ Check if completed verbally by MA

Patient Name: _____ Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Overall the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				
Total Score *(add your column score)*=				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

☐ Check if completed verbally by MA

Patient Name: _____ Date:_____

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the Past Week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get "going."	☐	☐	☐	☐

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Patient Name: _____ Date:_____

EPWORTH SLEEPINESS SCALE

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	_____

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Patient Name: _____ Date:_____

PITTSBURGH SLEEP QUALITY INDEX (PSQI)

INSTRUCTIONS: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

Please answer all questions.

During the past month …

1. What time have you usually gone to bed at night? _____
2. How long (in minutes) has it usually taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. How many hours of actual sleep did you get at night?
   (This may be different than the number of hours you spent in bed.) _____

5. During the past month, how often have you had trouble sleeping because you…	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				
	Very good	Fairly good	Fairly bad	Very bad
6. During the past month, how would you rate your sleep quality overall?				

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Patient Name: _____ Date:_____

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?				
8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	No bed partner or room mate	Partner/room mate in other room	Partner in same room, but not same bed	Partner in same bed
10. Do you have a bed partner or room mate?				
If you have a room mate or bed partner, ask him/her how often in the past month you have had…	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Loud snoring				
b. Long pauses between breaths while asleep				
c. Legs twitching or jerking while you sleep				
d. Episodes of disorientation or confusion during sleep				
e. Other restlessness while you sleep; please describe				

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Patient Name: _____ Date:_____

INSOMNIA SEVERITY INDEX

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

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