Welcome to the OHSU Sleep Disorders Program

Complete this questionnaire at home (preferably with someone that has observed your sleep the most). Bring this completed questionnaire, previous sleep medical records and any prior sleep equipment (ie CPAP equipment, dental devices) to your appointment. See last 2 pages for appointment detail and directions.

Name ____________________________ Male □ Female □
First             Middle initial               Last
Age_________ DOB ___________ □ Widowed  □ Married  □ Partnered □ Single
Height _______ Weight _______

Reason for appointment __________________________________________ Duration of problem __________
Other sleep problems you want to address

Prior Evaluations and Treatments Check “Yes” and provide details for items you’ve had. Check “No” if not applicable.

Sleep test or Apnea test □ No □ Yes, approximate dates and result:
Previous sleep diagnosis □ No □ Yes, details:
Sleep medications tried □ No □ Yes, list:
  Benefits □ No □ Yes, details:
  Side effects □ No □ Yes, details:
CPAP or BiPAP □ No □ Yes, approximate dates:
  Benefits □ No □ Yes, list:
  Problems □ No □ Yes, list:
Oxygen therapy □ No □ Yes, approximate dates:
Nose, throat or apnea surgeries □ No □ Yes, approximate dates and result:
Dental treatments for snoring □ No □ Yes, approximate dates and result:

Observations during sleep If possible, discuss the next 2 sections with people that observe your sleep the most

How often does someone sleep in your room or bed with you? □ nightly  □ weekly  □ monthly  □ rarely  □ never
People observing your sleep include: □ spouse  □ partner  □ girlfriend  □ boyfriend  □ child  □ parent  □ other:
✓ each item that you have done during sleep:  0 = Never  1 = Has happened  2 = Frequent (once per week or more)

0 1 2
□ □ □ Loud snoring
□ □ □ Light snoring
□ □ □ Hear yourself snoring
□ □ □ Pause/stop breathing
□ □ □ Gasp, snort or choke
□ □ □ Awaken short of breath
□ □ □ Dry mouth or sore throat
□ □ □ Wake with racing heart

0 1 2
□ □ □ Wake with headache
□ □ □ Wake with reflux or heart burn
□ □ □ Awaken in pain
□ □ □ Wake with sense of panic/fear
□ □ □ Awaken hot and sweaty
□ □ □ Menopausal hot flash/flushing
□ □ □ Compulsive late night eating
□ □ □ Sitting up in bed, not awake

0 1 2
□ □ □ Excessive movements
□ □ □ Twitching of legs, feet or arms
□ □ □ Kicking/jerking arms or legs
□ □ □ Restless, creepy-crawly sensations in legs
□ □ □ Unable to sleep due to restlessness
□ □ □ Wake with bedding in disarray
□ □ □ Groaning or moaning during sleep
□ □ □ Teeth grinding or jaw clenching
Observations during sleep continued  Place ✓ for each that you have ever done while asleep

- Sleep talking; from age _____ to age ___. How often now ______.

- Sleep walking; from age ______ to age ______. How often now ______. How far have you gone? ______.

- Nightmares; from age ______ to age ______. How often now ______. Nightmares decrease my quality of life ☐ Yes ☐ No

- Bed wetting; if beyond age 6, about what age did it resolve? ______. If persisting, how often? ______.

- * Acting out dreams or shouting; how many times per year? ______. What age did this start ______.

- * Hurt yourself or hurt someone else while you were sleeping; About how many times? ______.

  * If yes to either of these, please describe and provide details of worst case examples:

Daytime Symptoms (check all that apply)

- Poor attention/concentration ☐ Weight gain ☐ Depression ☐ Irritability ☐ Fatigue

- Diminished performance ☐ Change in personality ☐ I am too tired to do the activities I enjoy

- Often too tired to exercise ☐ Fatigue causes me problems ☐ Fatigue impairs my work, family or social life

How often do you wake with morning headaches: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

- Are you refreshed by a typical night’s sleep? ☐ Yes ☐ No

- Are you refreshed by naps? ☐ Yes ☐ No

Do you feel your sleepiness or fatigue is a result of poor sleep quality? ☐ Yes ☐ No

Do you think your sleepiness or fatigue is worsened by medications or substances you are taking? ☐ Yes ☐ No

  If yes, which medications or substances:

Excessive Sleepiness—Falling asleep easily during the day (check all that apply)

Do you have problems staying awake during the day? ☐ Yes ☐ No

If yes, what age did this begin? ______.

Have you had an accident because of sleepiness or dozing while driving? ☐ Yes ☐ No

  If yes, describe ____________________________________________

Have you had a near-miss while driving due to sleepiness? (dozing, nodding off, drifting onto rumble strip, other) ☐ Yes ☐ No

  If yes, describe ____________________________________________

Have you awoken feeling paralyzed, unable to move or trapped in your body? ☐ Yes ☐ No

  If yes, how often ______.

* Ever seen visions, heard sounds or hallucinated as you were falling asleep or waking up? ☐ Yes ☐ No

* Ever had sudden muscle weakness when feeling emotion (angry, surprise, or thinking of something funny) ☐ Yes ☐ No

* Ever dozed off in embarrassing or dangerous situations? ☐ Yes ☐ No

* If yes to any of last three, please describe:

Epworth Sleepiness Scale

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.

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

**PLEASE CIRCLE AN ANSWER FOR EACH LINE**

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>0  1  2  3</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>0  1  2  3</td>
</tr>
</tbody>
</table>

Total Score ______
Your Sleep Schedule and Sleep Habits
*Indicate your most common pattern for nights without and nights with usual obligations the following day*

<table>
<thead>
<tr>
<th>Days off</th>
<th>Work, school, childcare days <em>(Skip if no obligations)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time into bed</td>
<td>Time into bed</td>
</tr>
<tr>
<td>Lights off</td>
<td>Lights off</td>
</tr>
<tr>
<td>Alarm set at</td>
<td>Alarm set at</td>
</tr>
<tr>
<td>Out of bed to start your day</td>
<td>Out of bed to start your day</td>
</tr>
<tr>
<td>Total hours slept typical night off</td>
<td>Total hours slept typical work night</td>
</tr>
<tr>
<td>Total hours napping typical day off</td>
<td>Total hours napping typical work day</td>
</tr>
</tbody>
</table>

“Body Clock” or natural sleep-wake rhythm

Are you naturally late to bed and late to wake (night owl)? □ Yes □ No □ Maybe
Are you naturally early to bed and early to wake (morning type)? □ Yes □ No □ Maybe

If you had no obligations during a month vacation at home and slept at times that *best fit your body’s natural rhythm*
...what time would you fall asleep? _______ □AM □PM ...what time would you wake up? _______ □AM □PM

Given your current obligations (work, school, family, etc)
...what time should you go to sleep? _______ □AM □PM ...what time should you get up? _______ □AM □PM

Are you doing shift work, or expecting shift work? □ Yes □ No If yes, current shift: ____________
Do you often fly across 3 or more time zones? □ Yes □ No If yes, describe: ____________

Sleep environment *(check all that apply)*

What types of activity are you typically doing in the *hour before getting into bed*:
□ Computer □ TV □ Video games □ Work □ Childcare □ Other:

Electronic media used *after getting into bed*:
□ TV □ Internet □ Games □ Smart phone □ None □ Other:

Electronics left on *while you are sleeping*:
□ TV □ Music □ Lights □ None □ Other:

My room and/or bed is:
□ Dark □ Light □ Lights left on □ Comfortable □ Uncomfortable □ Quiet □ Loud

My sleep is disrupted by:
□ Partner □ Child □ Pet □ Nothing □ Other:

Which position do you prefer for sleep:
□ No preference □ Back □ Right side □ Left side □ Stomach □ Incline/Head elevated

Insomnia—Inability to sleep at night
□ I have no problem falling asleep and no problem staying asleep *(skip to next page)*

Do you have a problem *falling asleep in the beginning of the night*? □ No □ Yes
If yes, how many nights per month? _______ and how long does it take to fall asleep on bad nights? ____________

Do you have a problem with *brief awakenings (< 30 minutes each)*? □ No □ Yes
If yes, how many nights per month? _______, how many per night? _______ How long each? ____________

Do you have a problem with *long awakenings (> 30 minutes)*? □ No □ Yes
If yes, how many nights per month? _______, how many times per night? _______ How long each? ____________

How many minutes are spent in bed unable to sleep on a bad night? ____________ On a good night? ____________

Do you have long awakenings *worrying or thinking about daytime stressors*? □ Yes □ No
Do you have long awakenings *worrying or frustrated about being awake*? □ Yes □ No

Have you struggled with anxiety in recent months? □ Yes □ No
Have you struggled with depression in recent months? □ Yes □ No

How well do you sleep in hotels or away from home? □ Better □ No different □ Worse
WEIGHT HISTORY
My highest weight was at age ______, when I weighed about _______ pounds.
Weight history by age:
Age 20 _______ Age 30 _______ Age 40 _______ Age 50 _______ Age 60 _______
Compared to one year ago, I have □ gained □ maintained □ lost weight. If net gain or loss, how much:

MEDICAL HISTORY
Is all your medical care at OHSU? □ Yes □ No If no, please list medical problems and surgeries

FAMILY HISTORY
Indicate which sleep disorders your relatives have
□ Snoring □ Sleep Apnea □ Restless Legs Syndrome □ Sleep Walking □ Excessive sleepiness □ Insomnia

SOCIAL HISTORY
Employed: □ Yes □ No Occupation: ___________________________ People in my household: ___________________________

Substances
Do you currently smoke cigarettes? □ No □ Yes If you quit smoking, when did you quit? ___________________________
Years of cigarette smoking ________ Average packs of cigarettes per day while you were smoking __________
Have you ever smoked cigars, pipe, or chewed tobacco? □ No □ Yes Currently? □ No □ Yes
How many caffeinated cups per day of: coffee (8 oz) _______ tea (8 oz) _______ soft drinks (12 oz) _______
Have you used marijuana, methamphetamine, heroin or other illicit substances “street drugs”? □ No □ Yes
What/how often?

Do you currently drink alcohol? □ No □ Yes
On average, how many servings of alcohol per weekday = __________ servings per weekend = __________ servings per week = __________

Current general health review: please indicate symptoms you have experienced in the last two weeks

<table>
<thead>
<tr>
<th>General</th>
<th>Eyes</th>
<th>Gastrointestinal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Fever</td>
<td>□ Blurred vision</td>
<td>□ Heartburn/reflux</td>
<td>□ Easy bruising/bleeding</td>
</tr>
<tr>
<td>□ Chills</td>
<td>□ Double vision</td>
<td>□ Nausea</td>
<td>□ Allergies</td>
</tr>
<tr>
<td>□ Weight Loss</td>
<td>□ Light sensitivity</td>
<td>□ Vomiting</td>
<td>□ Excessive thirst</td>
</tr>
<tr>
<td>□ Fatigue</td>
<td>□ Eye pain</td>
<td>□ Abdominal pain</td>
<td></td>
</tr>
<tr>
<td>□ Excessive sweating</td>
<td>□ Eye drainage</td>
<td>□ Diarrhea</td>
<td></td>
</tr>
<tr>
<td>□ Weakness</td>
<td>□ Eye redness</td>
<td>□ Constipation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Heart</th>
<th>Urinary</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Rash</td>
<td>□ Chest Pain</td>
<td>□ Painful urination</td>
<td>□ Dizziness</td>
</tr>
<tr>
<td>□ Itching</td>
<td>□ Fast or irregular heart beat</td>
<td>□ Urgency</td>
<td>□ Tingling</td>
</tr>
<tr>
<td></td>
<td>□ Can’t breathe lying flat</td>
<td>□ Frequent urination</td>
<td>□ Tremor</td>
</tr>
<tr>
<td></td>
<td>□ Pain in legs with walking</td>
<td>□ Blood in urine</td>
<td>□ Change in sensation</td>
</tr>
<tr>
<td></td>
<td>□ Leg Swelling</td>
<td>□ Flank pain</td>
<td>□ Speech change</td>
</tr>
<tr>
<td></td>
<td>□ Waking up unable to breath</td>
<td></td>
<td>□ Specific weak area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
<th>Muscles and Bones</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Cough</td>
<td>□ Muscle aches/pain</td>
<td>□ Easy bruising/bleeding</td>
</tr>
<tr>
<td>□ Coughing up blood</td>
<td>□ Neck pain</td>
<td>□ Allergies</td>
</tr>
<tr>
<td>□ Coughing up mucus</td>
<td>□ Back pain</td>
<td>□ Excessive thirst</td>
</tr>
<tr>
<td>□ Shortness of Breath</td>
<td>□ Joint Pain</td>
<td></td>
</tr>
<tr>
<td>□ Wheezing</td>
<td>□ Falls</td>
<td></td>
</tr>
</tbody>
</table>

What else would you like us to know?
Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words “sleepy” or “tired” are used, it means the feeling that you can’t keep your eyes open, your head is droopy, that you want to “nod off” or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

**DIRECTIONS**: Please put a (✔) in the box for your answer to each question. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

**Q1.** Do you have difficulty concentrating on the things you do because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No

**Q2.** Do you generally have difficulty remembering things because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No

**Q3.** Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q4.** Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q5.** Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q6.** Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No

**Q7.** Do you have difficulty watching a movie or video because you become sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q8.** Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q9.** Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

**Q10.** Has your desire for intimacy or sex been affected because you are sleepy or tired?
- 1. Yes, extreme
- 2. Yes, moderate
- 3. Yes, a little
- 4. No
- 0. N/A

<table>
<thead>
<tr>
<th>Score</th>
<th>Patient Name: Last, First</th>
<th>MRN#</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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