SLEEP DISORDERS CENTER
General Sleep Assessment

Please complete and return with home sleep study unit.

Complete the following questionnaire by filling in the blanks and/or placing a check mark in the appropriate area.

What time do you usually go to bed? ____________________

Do you have difficulty falling asleep initially? □ Yes □ No
If you have difficulty, how long does it take to fall asleep? ____________________

Do you plan tomorrow’s activities while lying in bed? □ Yes □ No
Do thoughts racing through your mind keep you from sleeping? □ Yes □ No
Do thoughts keep you up after awakening during the night? □ Yes □ No
Do you have difficulty staying asleep during the night? □ Yes □ No
If yes, how many times do you wake up during the night? ____________________

How long does it take you to fall back to sleep? ____________________

When do you typically wake up to start your day? ____________________

Do you need an alarm clock? □ Yes □ No
Do you feel refreshed when you awaken to start your day? □ Yes □ No
Do you experience unsettled, restless legs while lying in bed? □ Yes □ No
If yes, how often? □ Rarely (25% of the time) □ Half (50% of the time) □ Most (75% of the time)

Have you been told you kick or twitch while sleeping? □ Yes □ No
Do you snore at night? □ Yes □ No
If you snore, how would you rate the severity? □ Mild □ Moderate □ Severe
Do you have pauses in your breathing or gasping while asleep? □ Yes □ No □ Don’t Know
If yes, how frequent are the pauses or gasping? □ Throughout the night □ Frequently □ Occasionally
Does your partner sleep in another room due to how you sleep? □ Yes □ No
Do you frequently wake up with any of these symptoms? □ Dry mouth □ Headache □ Chest pain □ Choking or gasping
□ Nasal congestion □ Aching jaws (teeth grinding)

Are you sleepy during the day? □ Yes □ No
Do you take naps often? □ Yes □ No
How many caffeinated beverages do you consume each day? ____________________ (8 oz cups)
Do you occasionally awaken feeling paralyzed? □ Yes □ No
Have you experienced loss of strength in your arms or legs? □ Yes □ No
If yes, are they brought on by a sudden fright or laughter? □ Yes □ No
Habits

Do you currently smoke? □ Yes □ No  If yes, how many per day? ________  Per week? ________
Do you drink alcohol? □ Yes □ No  If yes, how many drinks per day? ________  Per week? ________
Do you drink caffeine? □ Yes □ No  If yes, how many cups per day? ________  Per week? ________

Medical History:

Height: _______________  Weight: _______________

Please check any of the following medical conditions that you have a history of OR for which you are currently undergoing treatment:

- Arthritis
- Fibromyalgia/Chronic pain
- Chronic headaches
- Morning headaches
- Back problems
- Muscle Cramps
- Diabetes
- Hepatitis
- Heart problems/heart attack
- Irregular heart beat
- High blood pressure
- Low blood pressure
- Pacemaker
- Stroke
- Asthma
- COPD
- Sinus problems/nasal congestion
- Large tonsils/adenoids/uvula
- Depression/Anxiety
- Acid Reflux/heartburn
- Mental problems
- Seizures/Epilepsy
- Kidney/Bladder problems
- Prostate trouble

Please list any other medical conditions, medical or psychiatric, for which you are undergoing treatment:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Current Medications (attach separate page, if necessary)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergy to</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Previous Sleep Evaluation and Treatment

- I previously have had a sleep study. When?: ____________________ Where?: ________________________
- I am currently or have used titration therapy for home use. Pressure (if known) __________________ cm H20
- I have had surgical treatment for a sleep disorder. When? ____________________
- I am currently or have previously taken prescription sleep medication.
- I am currently or have previously taken over-the-counter sleep medication.
- I use oxygen. Number of liters (if known) _______________ All day □ Only at night □

List any recent surgeries (including year)

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

BED PARTNER SECTION

This final section covers information from your bed partner. Please state their name: ______________________________________

How often has your partner observed your sleep? □ Every night □ Often □ Once or twice □ Never

Check any of the following behaviors that your partner has observed while you sleep: □ Light snoring □ Sleepwalking
- Loud snoring □ Teeth grinding □ Sitting up in bed not awake □ Choking □ Twitching/kicking of arms and legs

Please describe the sleep behaviors checked 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.

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

According to your bed partner, have you ever fallen asleep during normal daytime activities or in dangerous situations?

□ Yes □ No

If yes, please explain:

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Page 3 of 3