ABOUT YOUR SLEEP

The purpose of this questionnaire is to help your carer understand the nature of your complaints and possible sleep disorder. This information will be treated as strictly confidential. In order to assist us in serving you better, please answer each question completely and as accurately as possible.

1. What time do you:
   a. **Go to bed** on *weekdays*? ______________________ On *weekends*? ______________________
   b. **Wake up** on *weekdays*? ______________________ On *weekends*? ______________________
2. How long does it take to **fall asleep after going to bed**?
   ____
3. How many times on average do you **wake up** during the night?
   ____
4. Do you have any **unusual sleep behaviours** (i.e. sleep walking, talking or night terrors)? Yes ☐ No ☐
5. Are you currently doing shift work or night shifts? Yes ☐ No ☐
   If YES please clarify your typical schedule:
   ____
   ____

Do you experience the following? If YES, ***Please ✓ & then circle. If unsure, indicate by "?".***

		RARELY	SOMETIMES	OFTEN			RARELY	SOMETIMES	OFTEN
☐	Act out your dreams	1	2	3	☐	Poor concentration	1	2	3
☐	Palpitations	1	2	3	☐	Feel hopeless or worthless	1	2	3
☐	Chest discomfort	1	2	3	☐	Feel depressed	1	2	3
☐	Libido/erectile problems	1	2	3	☐	Change in appetite	1	2	3
☐	Feelings of panic	1	2	3	☐	Low motivation	1	2	3
☐	Unable to relax	1	2	3	☐	Low in energy & tired	1	2	3
☐	Anxiety	1	2	3	☐	Loss of interest or pleasure doing things.	1	2	3
☐	Lapses in memory	1	2	3					

How often do you have (or been told you have) the following? ***Please circle.***

	NEVER	OCCASIONALLY	SOMETIMES	OFTEN	ALMOST ALWAYS
a. Snoring	0	1	2	3	4
b. Choking or gasping during sleep	0	1	2	3	4
c. Stop breathing during sleep	0	1	2	3	4
d. Nasal or sinus troubles (i.e. congestion, watery)	0	1	2	3	4
e. Difficulty falling asleep	0	1	2	3	4
f. Awakening during sleep	0	1	2	3	4
g. Feel unrefreshed after waking up	0	1	2	3	4
h. Restless sleep	0	1	2	3	4
i. Morning headaches	0	1	2	3	4
j. Jumpy or jerky legs	0	1	2	3	4
k. Uncomfortable sensation in your legs, which are better on moving them around.	0	1	2	3	4
l. When falling asleep or awakening, experience a hallucination (see or hear something that's not really there).	0	1	2	3	4
m. In response to strong emotions (e.g. laughter or anger) you experience sudden muscle weakness.	0	1	2	3	4

ABOUT YOUR SLEEP

How likely are you to dose off or fall asleep in the following situations?
This refers to your usual way of life in recent times. Even if you haven't done some of these things lately, try to work out how they would affect you.

Please circle

	NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
a. Sitting and reading	0	1	2	3
b. Watching TV	0	1	2	3
c. Sitting quietly in a public place (i.e. meeting)	0	1	2	3
d. Passenger in a car for an hour	0	1	2	3
e. Lying down for a rest in the afternoon	0	1	2	3
f. Sitting and talking to someone	0	1	2	3
g. Sitting quietly after lunch	0	1	2	3
h. In a car stopped for a few minutes in traffic	0	1	2	3
i. Driving	0	1	2	3

6. Have you ever **dozed off whilst driving**? Yes ☐ No ☐
7. Have you had **an accident or near miss as a result of sleepiness** or fatigue? Yes ☐ No ☐
8. Is there any additional information pertaining to your sleep evaluation that you feel is important?

____

____

MEDICAL HISTORY

Please list any present or past medical illnesses diagnosed by a doctor.

CONDITION	YEAR DIAGNOSED	CONDITION	YEAR DIAGNOSED
1.		5.	
2.		6.	
3.		7.	

MEDICATION

*Please list your regular **medications** (this includes prescription, herbals and over-the-counter).*

MEDICATION	DOSE	HOW MANY TIMES A DAY	MEDICATION	DOSE	HOW MANY TIMES A DAY

8. Have you every **smoked**? Yes ☐ No ☐

   If yes:

   Age started?__________ Age stopped?__________ How many per day? __________

9. How much **alcohol** do you have on average and at what times of the day?
10. How much **caffeinated drinks** (i.e. coffee, tea, cola) do you have a day? __________
11. Do you have any significant **allergies**? Yes ☐ No ☐

    If yes, please list & include reactions:

____

BED PARTNER'S QUESTIONS

Please have your bed partner fill this out independently.

Does your partner experience any of the following? If Yes please ✓ & then circle.

		RARELY	SOMETIMES	OFTEN			RARELY	SOMETIMES	OFTEN
☐	Loud snoring	1	2	3	☐	Breathing pauses	1	2	3
☐	Choking or gasping	1	2	3	☐	Kicking	1	2	3
☐	Sleep walking	1	2	3	☐	Sleep talking	1	2	3
☐	Teeth grinding	1	2	3	☐	Restless sleep	1	2	3

How **disruptive** can the snoring become?____

How **sleepy** do you think your partner gets during the day?
Please state how likely you think he or she is to fall asleep in the following situations (please circle)

		NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
a.	Sitting and reading	0	1	2	3
b.	Watching TV	0	1	2	3
c.	Sitting quietly in a public place	0	1	2	3
d.	Passenger in a car for an hour	0	1	2	3
e.	Lying down for a rest in the afternoon	0	1	2	3
f.	Sitting and talking to someone	0	1	2	3
g.	Sitting quietly after lunch	0	1	2	3
h.	In a car stopped for a few minutes in traffic	0	1	2	3
i.	Driving	0	1	2	3

CLINICAL NOTES (MEDICAL STAFF SECTION)