

CALIFORNIA CENTER FOR SLEEP DISORDERS

Name (First): _____ (MI) _____ (Last) _____

Age: _____ Weight: _____ Height: _____ Neck Size: _____ inches Occupation: _____

CHECK ONE BOX FOR EACH STATEMENT

SLEEP AND WAKE BEHAVIOR

- | | | <u>Never</u> | <u>Sometimes</u> | <u>Often</u> |
|-----|---|--------------------------|--------------------------|--------------------------|
| 1. | I have racing thoughts through my mind | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | I feel sad or depressed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | I have anxiety (worry about things) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | I feel muscular tension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | I feel unable to move | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | I have creeping, crawling, aching/twitching feeling
in my legs (feels like I have to constantly move them) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | I have vivid, dream-like scenes even though I know I
am not totally asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | I experience pain or discomfort | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | I feel afraid of the dark or something else | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | I suddenly become aware or alert | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | On average, how many hours of sleep do you get each night? _____ hours, _____ minutes | | | |

ABOUT SLEEPING

12. How much does your night amount of sleep time vary? From: _____ hrs, _____ minutes
To: _____ hrs, _____ minutes
13. How many times do you usually awaken each night? _____ Do you have trouble getting back
to sleep? Yes No
14. On a typical night, what is your longest period of wakefulness? _____ hrs, _____ minutes
15. How long are you awake all together during the night? _____ hrs, _____ minutes
16. If you awaken during the night, is it usually during the: 1st half of the night
 2nd half of the night

CHECK ONE BOX FOR EACH STATEMENT

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	
17. I feel afraid I won't return to sleep after awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. I sleep with someone else in my bed/in my room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. I have restless, disturbed sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. I get up at night to attend to my children or something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. I snore loudly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. I feel my heart pounding during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. I sweat a lot during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. I walk in my sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. I fall out of bed while asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. I wake up screaming, violent or confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. I have unusual movements while asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. I wet my bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. I have dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. I grind my teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. My sleep is frequently disturbed by: (CHECK ALL THAT ARE TRUE)				
<input type="checkbox"/> heat	<input type="checkbox"/> cold	<input type="checkbox"/> light	<input type="checkbox"/> noise	<input type="checkbox"/> noise or movement of bed partner
<input type="checkbox"/> asthma	<input type="checkbox"/> cough	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> choking	<input type="checkbox"/> indigestion, "gas" or heartburn
<input type="checkbox"/> hunger	<input type="checkbox"/> thirst	<input type="checkbox"/> need to urinate	<input type="checkbox"/> chest pain	<input type="checkbox"/> frightening dreams
<input type="checkbox"/> creeping, crawling, or aching feels in my legs (like I have to move them)				

ABOUT WAKING

32. What time do you usually have your final awakening? _____ am/pm
33. What time do you usually get out of bed after your final awakening? _____ am/pm

34. How much does your final awakening time vary? From: _____ am/pm To: _____ am/pm

CHECK ONE BOX FOR EACH STATEMENT

- | | <u>Never</u> | <u>Sometimes</u> | <u>Often</u> |
|--|--------------------------|--------------------------|--------------------------|
| 35. I depend on an alarm clock to wake up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. I "sleep-in" in the morning (more than 1 hour) past my usual wake up time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. I have a very hard time waking up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. I have vivid dream-like images when waking up even though I know I am not asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. I wake up confused or disoriented | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. I wake up with a headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. I wake up nauseous (sick to my stomach) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. I wake up with a dry mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. I wake up 1 or 2 hours before I have to get up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ABOUT DAYTIME FUNCTIONING

44. How many naps do you take in a usual week? _____
45. Are the naps refreshing? Yes No

CHECK ONE BOX FOR EACH STATEMENT

- | | <u>Never</u> | <u>Sometimes</u> | <u>Often</u> |
|---|--------------------------|--------------------------|--------------------------|
| 46. I feel sleepy during the day | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. I fall asleep unintentionally. Please give an example:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. I have thoughts racing through my mind | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. I feel sad or depressed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. I have anxiety (worry about things) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. I feel muscular tension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

52. I feel weakness in my muscles when laughing surprised, angry, excited, etc.

53. Does anyone in your family have a sleep problem? Yes No
Relationship to you: Describe the problem

54. How much of the following fluids do you drink?

	<u>During a typical day</u>	<u>Within 2 hrs before bedtime</u>
A. Coffee: caffeinated	_____ cups	_____ cups
decaffeinated	_____ cups	_____ cups
B. Tea	_____ cups	_____ cups
C. Soda: caffeinated	_____ cans	_____ cans
decaffeinated	_____ cans	_____ cans
D. Beer	_____ cans/oz.	_____ cans/oz.
E. Wine	_____ glasses/oz.	_____ glasses/oz.
F. Other alcoholic beverages	_____ glasses/oz.	_____ glasses/oz.

55. How much tobacco do you smoke during a 24 hour period?

A. Pack of cigarettes _____

B. Cigars _____

C. (Pipe) bowls _____

56. How often do you use (CHECK ONE BOX FOR EACH STATEMENT):

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>
A. Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hallucinogens (LSD, Mescaline, Angel dust, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Stimulants (uppers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Depressants (downers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Narcotics (heroin, morphine, opium, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

57. Please list the name and dose (in mg) of all medications that you take now or within the past 30 days:

<u>Medication</u>	<u>Dose</u>	<u>What for?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

58. Please list the name of any pill for sleeping or to help you stay awake that you have taken in the past.

Name

Did it help?

Yes No

Yes No

59. How many times each week do you participate in a sport or partake in some form of exercise?

60. What is your personal interpretation as to why you have your particular sleep/wake problem?

HEALTH HISTORY

61. Has your weight changed recently? Yes No If yes, explain: _____

62. Please check any problem or illness you have or have had:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing of the ears |
| <input type="checkbox"/> Black outs | <input type="checkbox"/> Hemophilia (bleeder) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Eye Trouble |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Muscle Cramps | | |

SURGERIES AND HOSPITALIZATIONS

Please list any hospitalizations and/or surgeries you have had. PLACE THE LATEST FIRST: include where, what, why, and when.

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?

Yes No

If yes, please explain: _____