The Christ Hospital Health Network

This questionnaire may not seem to pertain to your specific complaint; still answer them as best you can. The questionnaire is a broad based screening tool that is very helpful. Please consult family members or sleep partners on some questions.

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Preferred Name: _____

Height: _____ft. _____in. Weight: _____lbs. Shirt Collar Size: _____

Referring Physician: _____

A. SLEEP HISTORY (may elaborate in space provided at the end of this section)

How long have you had poor quality sleep?_____ years

Are you sleepy during the day?_____ If yes, for how long?_____ years

Does your bed partner complain about your snoring? _____ If yes, for how long? _____ years

Does your bed partner notice you stop breathing at night?_____If yes, for how long?_____years

Do you wake up at night with gasping /wake up from your snoring?_____

How many hours of sleep do you estimate you get at night?_____ hours

Have you been diagnosed with or treated for sleep apnea before? ☐ Yes ☐ No

B. SLEEP HABITS

1. What time do you go to bed on weekdays? _____AM/PM On weekends? _____AM/PM
2. What time do you wake up on weekdays? _____AM/PM On weekends? _____AM/PM
3. When you go to bed, how long does it usually take to fall asleep? _____ Minutes
4. When awakenings occur, are they associated with need to urinate? ☐ Yes ☐ No

   If yes, how many times you wake up to urinate during the night? _____
5. Do you take naps during the day? ☐ Yes ☐ No

   If yes, how many naps?_____
6. Do you feel that you suffer from insomnia? (difficulty falling or maintaining asleep)
   Yes ☐ No ☐
7. If yes, are you on any treatment for insomnia? Include any over the counter medications. _____
8. Do you have problems falling asleep OR maintaining asleep? Please describe_____

C. OTHER SLEEP RELATED PROBLEMS:

1. Do you have restless leg symptoms (urge to move your legs)? ☐ Yes ☐ No
   Are your restless leg symptoms worse during rest, like lying in bed? ☐ Yes ☐ No
   Are your restless leg symptoms better when you get up and walk? ☐ Yes ☐ No
   Are your restless leg symptoms worse during the evenings? ☐ Yes ☐ No

2. Do you have frequent early morning headaches? ☐ Yes ☐ No

3. Do you experience frequent nightmares? ☐ Yes ☐ No

4. Have you ever awoken from sleep with a feeling of muscular paralysis? ☐ Yes ☐ No
5. Have you ever developed muscular paralysis during wakefulness (particularly with periods of laughter or excitement)? ☐ Yes ☐ No
6. Have you ever been involved in an automobile accident related to your drowsiness? ☐ Yes ☐ No

D. OTHER MEDICAL PROBLEMS:

1. Are you suffering from any cardiac (heart) problems? ☐ Yes ☐ No
   If yes, please describe _____
2. Are you suffering from any pulmonary (lung) problems? ☐ Yes ☐ No
   If yes, please describe _____
3. Are you suffering from any allergy /sinus problems? ☐ Yes ☐ No
   If yes, please describe _____
4. Are you suffering from any Hypertension (blood pressure) problems? ☐ Yes ☐ No
   If yes, are you on treatment? _____
5. Are you suffering from any depression or mood disorders? ☐ Yes ☐ No
   If yes, are you on treatment? _____

E. SURGICAL HISTORY:

1. Have you had a tonsillectomy? ☐ Yes ☐ No If yes, when? _____
2. Have you had any sinus or nasal surgery? ☐ Yes ☐ No If yes, when?_____
3. Have you had any surgeries for snoring or sleep apnea? ☐ Yes ☐ No If yes, when? _____

F. PERSONAL HISTORY:

1. On average, how many caffeinated beverages do you consume per day? _____
2. Do you smoke? ☐ Yes ☐ No If yes, how many packs for how many years? _____
3. Were you a former smoker? ☐ Yes ☐ No If yes, how long did you smoke and when did you quit? _____
4. Do you drink alcohol prior to bedtime frequently? ☐ Yes ☐ No
5. Are you required to do shift work? ☐ Yes ☐ No
6. Please describe your work and work schedule _____

G. DIET AND EXERCISE HISTORY:

1. Have you tried any diet / weight loss therapy before? ☐ Yes ☐ No
   Explain diets you tried/for how long? _____
2. Do you exercise regularly? ☐ Yes ☐ No
   Explain your exercise habits _____
3. Have you had any recent change in body weight? ☐ Yes ☐ No
   Gained _____ lbs. Lost _____ lbs. Over how long? _____ years

H. FAMILY HISTORY:

1. Has anyone in your family had sleep apnea? ☐ Yes ☐ No

I. MEDICATION HISTORY:

PLEASE LIST ALL THE MEDICATIONS YOU TAKE INCLUDING THE DOSE AND HOW MANY TIMES A DAY: (ATTACH A SEPARATE SHEET IF NECESSARY)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not done some of these things, try to work out how these situations would affect you. Use the following scale:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	*chance of dozing*
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total	_____

FATIGUE SEVERITY SCALE (FSS)

It is important that you circle a number (1 to 7) for each question.

During the past week, I have found that:	Disagree ← → Agree						
1. My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. Exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. My fatigue prevents sustained physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7. Fatigue interferes with carrying out certain duties and responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8. Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9. Fatigue interferes with my work, family or social life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

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.

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?		☐	☐	☐	☐
2. Do you generally have difficulty remembering things, because you are sleepy or tired?		☐	☐	☐	☐
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
5. Do you have difficulty visiting with your family or friends in <u>their</u> home because you become sleepy or tired?	☐	☐	☐	☐	☐

	(4) No	(3) Yes, a little	(2) Yes, moderately	(1) Yes, extremely
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐	☐	☐	☐

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
7. Do you have difficulty watching a movie or videotape because you become sleepy or tired?	☐	☐	☐	☐	☐
8. Do you have difficulty being as active as you want to be in the <u>evening</u> because you are sleepy or tired?		☐	☐	☐	☐
9. Do you have difficulty being as active as you want to be in the <u>morning</u> because you are sleepy or tired?		☐	☐	☐	☐

	(0) I don't engage in sexual activity for other reasons	(4) No	(3) Yes, a little	(2) Yes, moderately	(1) Yes, extremely
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?	☐	☐	☐	☐	☐

Thank you for completing this questionnaire.