

Pre-study Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Your Height: _____ Your Weight: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?	Chance of Dozing Off			
	Never	Slight	Moderate	High
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly in a public place (theater or a meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while talking with someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please check one box per line

Brief Sleep Symptom Checklist

Never	Rarely	Often	Always	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I snore loudly
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I wake gasping or choking for breath
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I awaken in the morning unrefreshed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I have problems falling asleep or staying asleep (insomnia)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	My sleep is very restless
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	My sleep is disturbed by unusual behaviors (ex: nightmares, sleepwalking, dream enactments, tongue biting, bed-wetting)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fall asleep while driving
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I've been told that I stop breathing in my sleep (told by _____)

Please check the boxes that best describe you

Sleep Schedule

Please provide the following information

What time do you go to bed on **weekdays**? _____ AM or PM Do you take naps? Yes No

What time do you get up on **weekdays**? _____ AM or PM If yes, how often do you nap? _____ times per week

What time do you go to bed on **weekends**? _____ AM or PM How long are the naps? _____ minutes

What time do you get up on **weekends**? _____ AM or PM Do you awaken refreshed? Yes No

Are you a shift worker? Yes No If yes, what kind of shift do you work? _____

Patient Name: _____

Sleep Problems Checklist

What problem caused you to seek to our help? _____

How does this problem affect your life? _____

Check the circle for each problem you currently have.

- | | |
|---|--|
| <input type="radio"/> Loud snoring | <input type="radio"/> Teeth grinding during sleep |
| <input type="radio"/> Frequent awakenings at night | <input type="radio"/> Morning Headaches |
| <input type="radio"/> Choking for breath at night | <input type="radio"/> Morning dry mouth |
| <input type="radio"/> Gasping during sleep | <input type="radio"/> Sleep walking |
| <input type="radio"/> I've been told that I stop breathing when asleep | <input type="radio"/> Sleep terrors |
| <input type="radio"/> Restless sleep | <input type="radio"/> Tongue biting during sleep |
| <input type="radio"/> Awaken unrefreshed | <input type="radio"/> Bed wetting |
| <input type="radio"/> Crawling feeling in legs when trying to sleep | <input type="radio"/> Acting out dreams |
| <input type="radio"/> Leg-kicking during sleep | <input type="radio"/> Feeling paralyzed when falling asleep or waking up |
| <input type="radio"/> Leg cramps in sleep | <input type="radio"/> Dreamlike images when falling asleep or waking up |
| <input type="radio"/> Trouble falling asleep at night | <input type="radio"/> Sudden weakness when laughing |
| <input type="radio"/> Trouble staying asleep at night | <input type="radio"/> Sudden weakness when afraid |
| <input type="radio"/> Racing thoughts when trying to sleep | <input type="radio"/> Uncontrolled daytime sleep attacks |
| <input type="radio"/> Increased muscle tension when trying to sleep | <input type="radio"/> Falling asleep unexpectedly |
| <input type="radio"/> Fear of being unable to sleep | <input type="radio"/> Falling asleep at work |
| <input type="radio"/> Laying in bed worrying when trying to get to sleep | <input type="radio"/> Falling asleep at school |
| <input type="radio"/> Waking too early in the morning | <input type="radio"/> Falling asleep while driving |
| <input type="radio"/> Sleep talking | <input type="radio"/> Recent change in sleep schedule |
| <input type="radio"/> Sweating a lot at night | <input type="radio"/> I use sleeping pills to help me sleep |
| <input type="radio"/> Waking up with heartburn | <input type="radio"/> I use alcohol to help me sleep |
| <input type="radio"/> Waking up with reflux | <input type="radio"/> Pain interferes with sleep |
| <input type="radio"/> Waking up to urinate | |
| <input type="radio"/> Nightmares | |
| <input type="radio"/> Fear of being unable to return to sleep after waking at night | |

Where is the pain? _____

Patient Name: _____

Health & Family Questionnaire

1. How would you rate your current general health?

- Very poor
 Poor
 Average
 Good
 Very good

2. Check in you now have or in the past have had the following:

Diabetes	<input type="radio"/> Now	<input type="radio"/> Past	Anemia	<input type="radio"/> Now	<input type="radio"/> Past
High Blood Pressure	<input type="radio"/> Now	<input type="radio"/> Past	Peptic Ulcers	<input type="radio"/> Now	<input type="radio"/> Past
Stroke	<input type="radio"/> Now	<input type="radio"/> Past	Acid Reflux (Heartburn)	<input type="radio"/> Now	<input type="radio"/> Past
Heart Disease of CHF	<input type="radio"/> Now	<input type="radio"/> Past	Kidney Disease	<input type="radio"/> Now	<input type="radio"/> Past
Heart Attack	<input type="radio"/> Now	<input type="radio"/> Past	Thyroid Disease	<input type="radio"/> Now	<input type="radio"/> Past
Angina	<input type="radio"/> Now	<input type="radio"/> Past	Arthritis	<input type="radio"/> Now	<input type="radio"/> Past
Emphysema or COPD	<input type="radio"/> Now	<input type="radio"/> Past	Back Pain	<input type="radio"/> Now	<input type="radio"/> Past
Asthma	<input type="radio"/> Now	<input type="radio"/> Past	Head Trauma	<input type="radio"/> Now	<input type="radio"/> Past
Tuberculosis	<input type="radio"/> Now	<input type="radio"/> Past	Severe Headaches	<input type="radio"/> Now	<input type="radio"/> Past
Other Lung Disease	<input type="radio"/> Now	<input type="radio"/> Past	Epilepsy	<input type="radio"/> Now	<input type="radio"/> Past
Nasal Allergies	<input type="radio"/> Now	<input type="radio"/> Past	Passing Out (Fainting)	<input type="radio"/> Now	<input type="radio"/> Past
Runny or Blocked Nose	<input type="radio"/> Now	<input type="radio"/> Past	Depression	<input type="radio"/> Now	<input type="radio"/> Past
Hormonal Problem	<input type="radio"/> Now	<input type="radio"/> Past	Anxiety Disorder	<input type="radio"/> Now	<input type="radio"/> Past
Urological Problem	<input type="radio"/> Now	<input type="radio"/> Past	Problems w/ Alcohol	<input type="radio"/> Now	<input type="radio"/> Past
Prostate Disease	<input type="radio"/> Now	<input type="radio"/> Past	Problems w/ Drugs	<input type="radio"/> Now	<input type="radio"/> Past

3. Please list hospitalizations. Please give the reasons for each hospitalization and the dates (as best you can remember).

Reason for Hospitalization	Date

4. Please give important details about your medical conditions

Patient Name: _____

Health & Family Questionnaire

5. List your current average for each category below.

- _____ Hours worked per day
- _____ Days worked per week
- _____ Days of vacation per year
- _____ Number of cigarettes smoked per day
- _____ Other types of tobacco used per day (pipe or cigars)
- _____ Cups of regular coffee per day
- _____ Cups of tea per day
- _____ Glasses of cola or other caffeinated beverages per day
- _____ Cans of beer per day (12oz.)
- _____ Glasses of wine per day (3-4 oz.)
- _____ Alcoholic drinks per day (1-2 oz straight or mixed)

6. If you smoke or used to smoke...

What is the most per day you smoked? _____ If you quit, how long ago was it? _____

7. What is your current relationship status?

- Single Married Divorced Widowed Separated Living with someone

8. How many times have you been married? _____

9. What is your occupation? _____

10. Is your **father** living? Yes No If yes, how old is he? _____

If no, at what age did he die? _____ What caused his death? _____

What was your father's major occupation? _____

11. Is your **mother** living? Yes No If yes, how old is she? _____

If no, at what age did she die? _____ What caused her death? _____

What was your mother's major occupation? _____

12. Do any of your **brothers and/or sisters** have any major diseases or sleep disorders? If

yes, please describe (if applicable):

Patient Name: _____

Sleep Disorders Questionnaire

This portion of the questionnaire will give your doctor a good understanding about your problems with sleeping and waking. These questions have been designed to assist in detecting the patterns of behavior involved with various sleep disorders, so it is very important to answer each one.

In answering the questions, consider each question as applying to the past six months of your life, unless you have been told differently.

Some people work night shifts, or rotating shifts. Others have a very changeable bedtime. For these people, questions that ask about "day, daytime, morning, etc" will mean the time when they wake from their longest sleep of the day and become active. Similarly, "night, nighttime, bedtime, and nocturnal" all refer to the time of the day that they have their longest period of sleep.

Most of the questions are simple statements. You answer by circling a number from 1 to 5. If you strongly disagree with the statement, or it never happens to you, answer "1". If the statement is always true in your case, or you agree strongly with it, answer "5". You may also choose "2 rarely", "3 sometimes", or "4 usually" as your answer. Notice that an "answer key" appears at the bottom of each page to remind you what the numbers mean. Please answer all of the questions.

Here is an example of how to fill out a question:

How often does it snow in Florida in July?

1 2 3 4 5

If you are certain that a question does not apply to you, or never happens to you, use the answer "1".

Patient Name: _____

Sleep Disorders Questionnaire

- | | |
|--|-----------|
| 1. I am told that I snore loudly and bother others. | 1 2 3 4 5 |
| 2. I am told that I stop breathing ("hold my breath") in sleep. | 1 2 3 4 5 |
| 3. I wake suddenly gasping for breath, unable to breathe. | 1 2 3 4 5 |
| 4. I sweat a great deal at night. | 1 2 3 4 5 |
| 5. I have, or once had, high blood pressure. | 1 2 3 4 5 |
| 6. My nose blocks when I am trying to sleep (allergies, infections). | 1 2 3 4 5 |
| 7. My snoring or breathing-problem is worse if I sleep on my back. | 1 2 3 4 5 |
| 8. My snoring or breathing-problem is worse if I fall asleep right after drinking alcohol. | 1 2 3 4 5 |
| 9. When falling asleep, I feel paralyzed or unable to move. | 1 2 3 4 5 |
| 10. I feel unable to move, or paralyzed, after a nap. | 1 2 3 4 5 |
| 11. I have dream-like images (hallucinations) when I wake in the morning even though I know I am not asleep. | 1 2 3 4 5 |
| 12. I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long. | 1 2 3 4 5 |
| 13. I am very sleepy during the day and I struggle to stay awake. | 1 2 3 4 5 |
| 14. I have accidentally fallen asleep in some of these situations: eating a meal, talking on the phone or to someone, riding in a bus or car, watching TV, reading a book. | 1 2 3 4 5 |
| 15. I received poor grades in school because I was sleepy. | 1 2 3 4 5 |
| 16. I now have trouble doing my job because of sleepiness or fatigue. | 1 2 3 4 5 |
| 17. I often have to let someone else drive because I am too sleepy to do it. | 1 2 3 4 5 |
| 18. I see vivid dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen. | 1 2 3 4 5 |
| 19. I am often unable to move (paralyzed) when I am waking up in the morning. | 1 2 3 4 5 |
| 20. Sometimes I realize I have driven my car to the wrong place and I can't remember how I did it. | 1 2 3 4 5 |
| 21. I get "weak knees" when I laugh. | 1 2 3 4 5 |

1	2	3	4	5
Never	Rarely	Sometimes	Usually	Always
(Strongly Disagree)	(Disagree)	(Not Sure)	(Agree)	(Strongly Agree)

Patient Name: _____

Sleep Disorders Questionnaire

- | | | | | | |
|---|---|---|---|---|---|
| 22. I get brief periods of paralysis (being unable to move) when in situations of strong emotion. | 1 | 2 | 3 | 4 | 5 |
| 23. At bedtime, I worry about things. | 1 | 2 | 3 | 4 | 5 |
| 24. My sleep is disturbed by worrying about things. | 1 | 2 | 3 | 4 | 5 |
| 25. At bedtime, I feel muscle tension. | 1 | 2 | 3 | 4 | 5 |
| 26. At bedtime, I'm afraid of not being able to sleep. | 1 | 2 | 3 | 4 | 5 |
| 27. After waking at night, I fear I will not be able to get back to sleep. | 1 | 2 | 3 | 4 | 5 |
| 28. I wake up in the morning with a headache. | 1 | 2 | 3 | 4 | 5 |
| 29. I grind my teeth while I sleep. | 1 | 2 | 3 | 4 | 5 |
| 30. My sleep is disturbed by pain in my neck, back, muscles, joints, legs, or arms. | 1 | 2 | 3 | 4 | 5 |
| 31. I have trouble getting to sleep at night. | 1 | 2 | 3 | 4 | 5 |
| 32. At bedtime, thoughts race through my mind. | 1 | 2 | 3 | 4 | 5 |
| 33. At bedtime, I feel sad and depressed. | 1 | 2 | 3 | 4 | 5 |
| 34. My sleep is disturbed by sadness or depression. | 1 | 2 | 3 | 4 | 5 |
| 35. I have a lot of nightmares and frightening dreams. | 1 | 2 | 3 | 4 | 5 |
| 36. I have been unable to sleep <u>at all</u> for several days. | 1 | 2 | 3 | 4 | 5 |
| 37. I am unhappy about loving relationships in my life. | 1 | 2 | 3 | 4 | 5 |
| 38. I have considered or attempted suicide. | 1 | 2 | 3 | 4 | 5 |
| 39. Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown". | 1 | 2 | 3 | 4 | 5 |
| 40. I wake up often during the night. | 1 | 2 | 3 | 4 | 5 |
| 41. When falling asleep, I have "restless legs" (a feeling of crawling, aching, or inability to keep legs still). | 1 | 2 | 3 | 4 | 5 |
| 42. At night my heart pounds, beats rapidly, or beats irregularly ("palpitations"). | 1 | 2 | 3 | 4 | 5 |
| 43. My sleep is disturbed by "restless legs" (a feeling of crawling, aching, or inability to keep legs still). | 1 | 2 | 3 | 4 | 5 |
| 44. I feel that I have insomnia. | 1 | 2 | 3 | 4 | 5 |
| 45. My desire or interest in sex is less than it used to be. | 1 | 2 | 3 | 4 | 5 |
| 46. I smoke tobacco within two hours of bedtime. | 1 | 2 | 3 | 4 | 5 |

1	2	3	4	5
Never	Rarely	Sometimes	Usually	Always
(Strongly Disagree)	(Disagree)	(Not Sure)	(Agree)	(Strongly Agree)

Patient Name: _____

Sleep Disorders Questionnaire

47. How long is your longest wake period at night?	<input type="radio"/> Less than 5 <input type="radio"/> minutes 6 to 19 <input type="radio"/> minutes 20-59 <input type="radio"/> minutes 1-2 hours <input type="radio"/> More than 2 hours
48. How many times in a night do you get up to urinate?	<input type="radio"/> None <input type="radio"/> Once <input type="radio"/> Twice <input type="radio"/> Three times <input type="radio"/> Four or more times
49. How many work accidents have you had as a result of sleepiness or fatigue?	<input type="radio"/> None <input type="radio"/> Once <input type="radio"/> Twice <input type="radio"/> Three times <input type="radio"/> Four or more times
50. What is your current weight (in lbs)?	<input type="radio"/> 134 lbs or less <input type="radio"/> 135-159 lbs. <input type="radio"/> 160-183 lbs. <input type="radio"/> 184-209 lbs. <input type="radio"/> 210 lbs. or more.
51. How many years were you a smoker?	<input type="radio"/> Never smoked <input type="radio"/> 1 year <input type="radio"/> 2-12 years <input type="radio"/> 13-25 years <input type="radio"/> 26 yrs or more
51. How old are you now?	<input type="radio"/> 25 or younger <input type="radio"/> 26-35 <input type="radio"/> 36-44 <input type="radio"/> 45-50 <input type="radio"/> 51 or older

Patient Name: _____

Zung Depression Scale

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

	None, or a little of the time	Some of the time	Good part of the time	Most of the time
I feel down-hearted, blue, and sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Morning is when I feel the best	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have crying spells or feel like it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble sleeping through the night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I eat as much as I used to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoy looking at, talking to, and being with attractive women/men	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I notice that I am losing weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble with constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My heart beats faster than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get tired for no reason	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My mind is as clear as it use to be	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it easy to do the things I used to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am restless and can't keep still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel hopeful about the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am more irritable than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it easy to make decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I am useful and needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My life is pretty full	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that others would be better off if I were dead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I still enjoy the things I used to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Adapted from ZUNG, A Self-rating depression scale, Arch general Psychiatry, 1965; 12:63-70

A few suggestions to prepare for your sleep study.

In the days leading up to your study, try to follow your normal sleep routine and habits. Arrive for testing neither deprived of sleep nor over-rested. As best as you can, avoid taking any naps on the day of your study.

Try to avoid any products containing caffeine (coffee, tea, carbonated beverages, chocolate) after 2pm on the day of the study. Also, alcohol is known to disrupt sleep so avoid its use prior to the test as well.

Take a shower or bath before leaving home, but do not apply sprays, oils, or gels to your hair. Wash any make-up off, and avoid any skin creams or lotions.

You will be asked to remove any earrings or necklaces, so you may consider leaving them at home.

Bring a list of medications you are currently taking, as well as any necessary medicine as prescribed by your physician. Remember to pack comfortable, loose fitting clothes to sleep in.

Please arrive at the BSL Sleep Lab at your scheduled time.

After the study, which should be completed by 6:30am, there will be a short questionnaire and then you'll be ready for check-out.

Have a great day and a restful night's sleep.

BSL Bastrop - 441 Highway 71 W - 512-303-4997
We are located behind the Bastrop Medical Center building.

We look forward to serving you,

Bastrop Sleep Lab Staff

