SLEEP DISORDERS PROGRAM
New Patient Questionnaire

Hatfield Research Building, 13th floor (next to Elevator E)
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Welcome to the OHSU Sleep Disorders Program

Complete this questionnaire at home (preferably with someone that has observed your sleep the most). Bring this completed questionnaire, previous sleep medical records and any prior sleep equipment (ie CPAP equipment, dental devices) to your appointment. See last 2 pages for appointment detail and directions.

Name _____ Male ☐ Female ☐
First Middle initial Last

Age_____ DOB _____ ☐Widowed ☐Married ☐Partnered ☐Single Height _____Weight _____

Reason for appointment _____ Duration of problem _____

Other sleep problems you want to address

Prior Evaluations and Treatments *Check "Yes" and provide details for items you've had. Check "No" if not applicable.*

Sleep test or Apnea test	☐ No	☐ Yes, approximate dates and result:
Previous sleep diagnosis	☐ No	☐ Yes, details:
Sleep medications tried	☐ No	☐ Yes, list:
Benefits	☐ No	☐ Yes, details:
Side effects	☐ No	☐ Yes, details:
CPAP or BiPAP	☐ No	☐ Yes, approximate dates:
Benefits	☐ No	☐ Yes, list:
Problems	☐ No	☐ Yes, list:
Oxygen therapy	☐ No	☐ Yes, approximate dates:
Nose, throat or apnea surgeries	☐ No	☐ Yes, approximate dates and result:
Dental treatments for snoring	☐ No	☐ Yes, approximate dates and result:

Observations during sleep *If possible, discuss the next 2 sections with people that observe your sleep the most*

How often does someone sleep in your room or bed with you? ☐ nightly ☐ weekly ☐ monthly ☐ rarely ☐ never
People observing your sleep include: ☐ spouse ☐ partner ☐ girlfriend ☐ boyfriend ☐ child ☐ parent ☐ other:

✓ *each item that <u>you</u> have done during sleep:* ***<u>0</u> = Never <u>1</u> = Has happened <u>2</u> = Frequent (once per week or more)***

0 1 2	0 1 2	0 1 2
☐ ☐ ☐ Loud snoring	☐ ☐ ☐ Wake with headache	☐ ☐ ☐ Excessive movements
☐ ☐ ☐ Light snoring	☐ ☐ ☐ Wake with reflux or heart burn	☐ ☐ ☐ Twitching of legs, feet or arms
☐ ☐ ☐ Hear yourself snoring	☐ ☐ ☐ Awaken in pain	☐ ☐ ☐ Kicking/jerking arms or legs
☐ ☐ ☐ Pause/stop breathing	☐ ☐ ☐ Wake with sense of panic/fear	☐ ☐ ☐ Restless, creepy-crawly sensations in legs
☐ ☐ ☐ Gasp, snort or choke	☐ ☐ ☐ Awaken hot and sweaty	☐ ☐ ☐ Unable to sleep due to restlessness
☐ ☐ ☐ Awaken short of breath	☐ ☐ ☐ Menopausal hot flash/flushing	☐ ☐ ☐ Wake with bedding in disarray
☐ ☐ ☐ Dry mouth or sore throat	☐ ☐ ☐ Compulsive late night eating	☐ ☐ ☐ Groaning or moaning during sleep
☐ ☐ ☐ Wake with racing heart	☐ ☐ ☐ Sitting up in bed, not awake	☐ ☐ ☐ Teeth grinding or jaw clenching

Observations during sleep continued *Place ✓for each that you have ever done while asleep*

☐ **Sleep talking**; from age _____ to age _____ How often now _____

☐ **Sleep walking**; from age _____ to age _____ How often now _____ How far have you gone? _____

☐ **Nightmares**; from age _____ to age _____ How often now _____ Nightmares decrease my quality of life ☐Yes ☐No

☐ **Bed wetting**; if beyond age 6, about what age did it resolve? _____ If persisting, how often? _____

☐ * **Acting out dreams or shouting**; how many times per year? _____ What age did this start _____

☐ * **Hurt yourself or hurt someone else** while you were sleeping; About how many times? _____

* If yes to either of these, please describe and provide details of worst case examples:

Daytime Symptoms *(check all that apply)*

☐Poor attention/concentration ☐Weight gain ☐Depression ☐Irritability ☐Fatigue

☐Diminished performance ☐Change in personality ☐I am too tired to do the activities I enjoy

☐Often too tired to exercise ☐Fatigue causes me problems ☐Fatigue impairs my work, family or social life

How often do you wake with morning headaches: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Are you refreshed by a typical night's sleep? ☐ Yes ☐ No

Are you refreshed by naps? ☐ Yes ☐ No

Do you feel your sleepiness or fatigue is a result of poor sleep ***quality***? ☐ Yes ☐ No

Do you think your sleepiness or fatigue is worsened by medications or substances you are taking? ☐Yes ☐No

If yes, which medications or substances:

Excessive Sleepiness—Falling asleep easily during the day *(check all that apply)*

Do you have problems staying awake during the day? ☐Yes ☐No If yes, what age did this begin?_____

Have you had an accident because of sleepiness or dozing while driving ?

☐Yes ☐No If yes, describe _____

Have you had a near-miss while driving due to sleepiness? (dozing, nodding off, drifting onto rumble strip, other)

☐Yes ☐No If yes, describe _____

Have you awoken feeling paralyzed, unable to move or trapped in your body? ☐ Yes ☐ No If yes, how often _____

* Ever seen visions, heard sounds or hallucinated as you were falling asleep or waking up? ☐Yes ☐No

* Ever had sudden muscle weakness when feeling emotion (angry, surprise, or thinking of something funny) ☐Yes ☐No

* Ever dozed off in embarrassing or dangerous situations? ☐Yes ☐No

* If yes to any of last three, please describe:

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

PLEASE CIRCLE AN ANSWER FOR EACH LINE

SITUATION	CHANCE OF DOZING				
Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting inactive in a public place (e.g. a theater or a meeting)	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after a lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	Total Score _____

Your Sleep Schedule and Sleep Habits

Indicate your <u>most common</u> pattern for nights without and nights with usual obligations the following day

<u>Days off</u>

Time into bed _____ ☐AM ☐PM
Lights off _____ ☐AM ☐PM
Alarm set at _____ ☐AM ☐PM
Out of bed to start your day _____ ☐AM ☐PM
Total hours slept typical night off _____
Total hours napping typical day off _____

<u>Work, school, childcare days</u> *<u>(Skip if no obligations)</u>*

Time into bed _____ ☐AM ☐PM
Lights off _____ ☐AM ☐PM
Alarm set at _____ ☐AM ☐PM
Out of bed to start your day _____ ☐AM ☐PM
Total hours slept typical work night _____
Total hours napping typical work day _____

"Body Clock" or natural sleep-wake rhythm

Are you naturally late to bed and late to wake (night owl)? ☐ Yes ☐ No ☐ Maybe
Are you naturally early to bed and early to wake (morning type)? ☐ Yes ☐ No ☐ Maybe
If you had no obligations during a month vacation at home and slept at times that **best fit your body's natural rhythm**
…what time would you fall asleep? _____ ☐AM ☐PM …what time would you wake up? _____ ☐AM ☐PM
Given **your current obligations (work, school, family, etc)**
…what time should you go to sleep?_____ ☐AM ☐PM …what time should you get up? _____ ☐AM ☐PM
Are you doing shift work, or expecting shift work? ☐ Yes ☐ No If yes, current shift:
Do you often fly across 3 or more time zones? ☐ Yes ☐ No If yes, describe:

Sleep environment *(check all that apply)*

What types of activity are you typically doing in the ***hour before getting into bed***:
☐Computer ☐TV ☐Video games ☐Work ☐Childcare ☐ Other:
Electronic media used ***after getting into bed***:
☐TV ☐Internet ☐Games ☐Smart phone ☐None ☐Other:
Electronics left on ***while you are sleeping***:
☐TV ☐Music ☐Lights ☐None ☐Other:
My room and/or bed is:
☐Dark ☐Light ☐Lights left on ☐Comfortable ☐Uncomfortable ☐Quiet ☐Loud
My sleep is disrupted by:
☐Partner ☐Child ☐Pet ☐Nothing ☐ Other:
Which position do you prefer for sleep:
☐No preference ☐Back ☐Right side ☐Left side ☐Stomach ☐Incline/head elevated

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Insomnia—Inability to sleep at night

☐ I have no problem falling asleep and no problem staying asleep *(skip to next page)*

Do you have a problem **falling asleep in the beginning of the night**? ☐ No ☐ Yes
If yes, how many nights per month? _____, and how long does it take to fall asleep on bad nights? _____
Do you have a problem with **brief awakenings (< 30 minutes each)**? ☐ No ☐ Yes
If yes, how many nights per month? _____, how many per night? _____ How long each? _____
Do you have a problem with **long awakenings (> 30 minutes)**? ☐ No ☐ Yes
If yes, how many nights per month? _____, how many times per night? _____ How long each? _____
How many minutes are spent in bed unable to sleep on a bad night? _____ On a good night? _____
Do you have long awakenings **worrying or thinking about daytime stressors**? ☐ Yes ☐ No
Do you have long awakenings **worrying or frustrated about being awake**? ☐ Yes ☐ No
Have you struggled with anxiety in recent months? ☐Yes ☐No
Have you struggled with depression in recent months? ☐Yes ☐No
How well do you sleep in hotels or away from home? ☐ better ☐ no different ☐ worse

WEIGHT HISTORY

My highest weight was at age _____ , when I weighed about _____ pounds.

Weight history by age:

Age 20 _____ Age 30 _____ Age 40 _____ Age 50 _____ Age 60 _____

Compared to one year ago, I have ☐ gained ☐ maintained ☐ lost weight. If net gain or loss, how much:

MEDICAL HISTORY Is all your medical care at OHSU? ☐Yes ☐No If no, please list medical problems and surgeries

FAMILY HISTORY *Indicate which sleep disorders your relatives have*

☐ Snoring ☐ Sleep Apnea ☐ Restless Legs Syndrome ☐ Sleep Walking ☐ Excessive sleepiness ☐ Insomnia

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SOCIAL HISTORY

Employed: ☐Yes ☐No Occupation: _____ People in my household: _____

Substances

Do you currently smoke cigarettes? ☐No ☐Yes If you quit smoking, when did you quit? _____

Years of cigarette smoking _____ Average packs of cigarettes per day while you were smoking_____

Have you ever smoked cigars, pipe, or chewed tobacco? ☐No ☐Yes Currently? ☐No ☐Yes

How many **caffeinated** cups per day of: coffee (8 oz) _____ tea (8 oz) _____ soft drinks (12 oz) _____

Have you used marijuana, methamphetamine, heroin or other illicit substances *"street drugs"*? ☐No ☐Yes

What/how often? _____

Do you currently drink alcohol? ☐No ☐ Yes

On average, how many servings of alcohol per weekday = servings per weekend = servings per week =

Current general health review: *please indicate symptoms you have experienced in the last two weeks*

General	**Eyes**	**Gastrointestinal**	**Other**
☐ Fever	☐ Blurred vision	☐ Heartburn/reflux	☐ Easy bruising/bleeding
☐ Chills	☐ Double vision	☐ Nausea	☐ Allergies
☐ Weight Loss	☐ Light sensitivity	☐ Vomiting	☐ Excessive thirst
☐ Fatigue	☐ Eye pain	☐ Abdominal pain	
☐ Excessive sweating	☐ Eye drainage	☐ Diarrhea	**Neurological**
☐ Weakness	☐ Eye redness	☐ Constipation	☐ Dizziness
		☐ Blood in the stool	☐ Tingling
Skin	**Heart**		☐ Tremor
☐ Rash	☐ Chest Pain	**Urinary**	☐ Change in sensation
☐ Itching	☐ Fast or irregular heart beat	☐ Painful urination	☐ Speech change
	☐ Can't breathe lying flat	☐ Urgency	☐ Specific weak area
Ears, Nose and Throat	☐ Pain in legs with walking	☐ Frequent urination	☐ Seizure
☐ Headaches	☐ Leg Swelling	☐ Blood in urine	☐ Loss of consciousness
☐ Hearing loss	☐ Waking up unable to breath	☐ Flank pain	
☐ Tinnitus/ringing in ears			**Mental Function**
☐ Ear pain	**Lungs**	**Muscles and Bones**	☐ Depression
☐ Ear discharge	☐ Cough	☐ Muscle aches/pain	☐ Suicidal ideas
☐ Nosebleeds	☐ Coughing up blood	☐ Neck pain	☐ Nervous/Anxious
☐ Nasal congestion	☐ Coughing up mucous	☐ Back pain	☐ Memory loss
☐ High pitched wheezing	☐ Shortness of Breath	☐ Joint Pain	
☐ Sore throat	☐ Wheezing	☐ Falls	

What else would you like us to know?

Functional Outcomes of Sleep Questionnaire **F.O.S.Q. – 10**

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.

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Q10. Has your desire for intimacy or sex been affected because you are sleepy or tired?

1. Yes, extreme	2. Yes, moderate	3. Yes, a little	4. No	0. N/A

Score	**Patient Name: Last, First**	**MRN#**	**Today's Date**