

Hawthorn Sleep Center

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PRE-STUDY PATIENT QUESTIONNAIRE

Date: _____

1. Name: _____ Sex: _____ Age: _____

2. Address: _____

3. Telephone number - Home: _____ Work: _____

4. Estimate how many hours of sleep you get:

- a. On a good night _____
- b. On a bad night _____

5. Estimate how long it takes you to fall asleep:

- a. On a good night _____
- b. On a bad night _____

6. What time do you typically go to bed?

- a. On a work day _____
- b. On a non-work night _____

7. What time do you typically get out of bed?

- a. On a work day _____
- b. On a non-work night _____

8. Does your job require that you change shifts? Yes No

If yes, how often? _____

What shifts do you work? _____

Please describe your sleep patterns if you work third shift or rotating shifts:

9. How often do you travel across time zones? _____ times per month.

10. Do you do any of the following activities in bed:

	No	Once a month or less	Once a week or less	Few times a week	Daily
a. Read in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Watch TV in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eat in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Work in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Argue in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Worry in bed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you ever wake up during the night after initially falling asleep: Yes No

a. If yes, how often (circle one)

1 - 3 nights 1 - 2 nights several nights every night
a month a week a week

b. How many times a night do you generally wake up: _____

c. Estimate how long you are awake during the night after initially falling asleep:
_____ minutes _____ hours

12. How many nights during an average week does it take you at least 30 minutes either to fall asleep or to return to sleep?

_____ nights per week

13. How many mornings during the average week do you wake up at least 1 hour before your normal wake-up time and cannot return to sleep?

_____ mornings per week

14. When you have difficulty either falling asleep or getting back to sleep, what do you do? (check all that apply)

- Stay in bed and try to get to sleep
- Do something in bed (e.g., read or watch T.V.)
- Get up and read
- Get up and watch T.V.
- Get up and eat
- Get up and drink alcohol
- Get up and drink warm milk
- Get up and drink soda/water/coffee/tea
- Other (please specify) _____

15. Please circle a number from 1 - 10 to indicate how much difficulty you have relaxing away tension in your body while trying to sleep.

1 2 3 4 5 6 7 8 9 10
No Difficulty Some Difficulty Great Difficulty

16. Please circle a number from 1 - 10 to indicate how much difficulty you have in "slowing down" or "turning off" your mind while trying to sleep.

1 2 3 4 5 6 7 8 9 10
No Difficulty Some Difficulty Great Difficulty

17. Do you currently use medications (over-the-counter or prescription) to help you sleep? Yes No

If Yes:

a. How often (circle one): Once a month or less Once a week or less Few times a week Nightly

b. Please list all medications you use to help you sleep:

<u>Name</u>	<u>Amount</u>	<u>How long you have used this medicine</u>	<u>Medication made you feel (circle one)</u>		
_____	_____	_____	better	no change	worse
_____	_____	_____	better	no change	worse
_____	_____	_____	better	no change	worse

If No:

a. Have you ever used medications in the past (over-the-counter or prescription) to help you sleep?

Yes No

b. If yes, list all medications:

<u>Name</u>	<u>Amount</u>	<u>How long you have used this medicine</u>	<u>Medication made you feel (circle one)</u>		
_____	_____	_____	better	no change	worse
_____	_____	_____	better	no change	worse
_____	_____	_____	better	no change	worse

18. Do you currently have a bed partner? Yes No
19. Has anyone ever told you that you snore loudly? Yes No
- a. If yes, has your snoring caused people to refuse to sleep in the same room with you? Yes No
20. Has anyone ever told you that you seem to stop breathing while you sleep, or wake up gasping for breath? Yes No
21. Have you ever awoken with the sensation that you are not breathing? Yes No
22. Has anyone ever noticed that your legs periodically twitch during the night? Yes No
23. Have you ever had an uncomfortable feeling in your legs that has made it difficult for you to fall asleep? Yes No
24. Do you ever wake up stiff and sore in the morning? Yes No
25. Have you ever been unable to move when falling asleep or immediately upon awakening? Yes No
26. Have you ever had episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry, or in other emotional situations? Yes No

- | | No | Once a month or less | Once a week or less | Few times a week | Daily |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 27. Do you ever: | | | | | |
| a. Wake up with a morning headache: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Walk in your sleep without realizing it: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Wake up confused and wander during the night: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have nightmares: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have fearful thoughts and images as you fall asleep: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you ever experience severe sleepiness during the daytime (e.g. struggling to stay awake)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you fall asleep without meaning to during the day? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

30. During the past six months, have you ever had episodes of either struggling to stay awake or falling asleep without meaning to in any of the following situations?
- | | No | Once a month
or less | Once a week
or less | Few times
a week | Daily |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Reading (not in bed) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Watching T.V. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During conversation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. At work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
31. Do you ever have problems with your performance at work because of sleepiness? Yes No
32. Have you ever had a car accident(s) caused by your sleepiness (not due to alcohol or drugs) Yes No
33. Have you ever had a near car accident(s) ("close calls") caused by your sleepiness (not due to alcohol or drugs)? Yes No
34. How many naps do you take during the average week? _____
- a. How long is your average nap? _____ minutes or _____ hours
35. Does a nap generally restore you? Yes No
36. How long have you had difficulty with sleep? (check one)
- less than a month
 - 1 - 6 months
 - 6 - 12 months
 - 1 - 5 years
 - more than 5 years
37. Did you have sleep problems as a child? Yes No
38. Have your problems with sleep ever increased in severity? Yes No
If yes, when did you notice an increase in severity? _____
39. To what do you attribute the cause of your sleep problem? (check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Stress at work | <input type="checkbox"/> Poor sleep habits |
| <input type="checkbox"/> Relationship problems with spouse | <input type="checkbox"/> Poor eating habits |
| <input type="checkbox"/> Relationship problems with children | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Financial problems | _____ |
| <input type="checkbox"/> Sexual problems | _____ |
40. Drinking History:
About how often did you drink during the past 30 days? Please place one check next to the frequency indicator under each type of alcoholic beverage.
- | | | |
|--|--|--|
| <input type="checkbox"/> Beer | <input type="checkbox"/> Liquor | <input type="checkbox"/> Wine |
| <input type="checkbox"/> Every day | <input type="checkbox"/> Every day | <input type="checkbox"/> Every day |
| <input type="checkbox"/> 5 to 6 days per week | <input type="checkbox"/> 5 to 6 days per week | <input type="checkbox"/> 5 to 6 days per week |
| <input type="checkbox"/> 3 to 4 days per week | <input type="checkbox"/> 3 to 4 days per week | <input type="checkbox"/> 3 to 4 days per week |
| <input type="checkbox"/> 1 to 2 times per week | <input type="checkbox"/> 1 to 2 times per week | <input type="checkbox"/> 1 to 2 times per week |
| <input type="checkbox"/> 1 time weekly | <input type="checkbox"/> 1 time weekly | <input type="checkbox"/> 1 time weekly |
| <input type="checkbox"/> 1 to 3 times a month | <input type="checkbox"/> 1 to 3 times a month | <input type="checkbox"/> 1 to 3 times a month |
| <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None |

41. In the past 30 days, how much have you been drinking each time you drink? (on the average). Please place a check next to the quantity indicator under each alcoholic beverage.

Beer: at a sitting

- 12 or more bottles
- 7 to 12 bottles
- 5 to 6 bottles
- 3 to 4 bottles
- 1 to 2 bottles
- None

Liquor: at a sitting

- 4 pints or more
- 3 pints
- 2 pints
- 1 pint (16 oz.)
- 8 to 10 shots/drinks
- 5 to 7 shots/drinks
- 3 to 4 shots/drinks
- 1 to 2 shots/drinks (1 shot = 1.5 oz.)
- None

Wine: at a sitting

- 3 liters or more
- 2 liters (about 64 ounces)
- 1 liter (about 32 ounces)
- 6 to 7 wine glasses (24 to 28 oz.)
- 2 water glasses or 3 to 5 wine glasses (12 to 20 oz.)
- 1 water glass or 1 to 2 wine glasses (4 to 8 oz.)
- None

42. Do you engage in regular (at least once per week) exercise? Yes No

a. If yes, how often (check one)

- daily
- 5 to 6 days a week
- 3 to 4 days a week
- 1 to 2 days a week
- once weekly

b. At what time of the day do you usually exercise? _____

43. Please answer the following questions based on *your* beliefs for an average person your age *without* sleep problems:

- a. How many hours of sleep per night does the average person get? _____ hours
- b. How long does it take the average person to get to sleep? _____ minutes
- c. How many times does the average person wake up during the night? _____ times
- d. How long does the average person spend awake in bed during the night? _____ minutes
or _____ hours

