Dr.N. Ramakrishnan
AB (Int Med), AB (Crit Care), MMM, FACP, FCCP, FCCM

This questionnaire will give your doctor a good understanding of your problems with sleeping and waking. Consider each question as applying to the **past six months.**

Date : _____/_____/ _____ Referring Physician : ________________________________

Name : ________________ Sex : Male Female Date of Birth : _____/_____/ ____

Age : ________________

Please answer all questions.

Sleep History

What time do you usually go to bed ? _____ : ______

How long does it take you to fall asleep ? ______ minutes

While you are either falling asleep or waking up do you experience

dream like images (hallucinations) ? ☐ Yes ☐ No

feel paralyzed ? ☐ Yes ☐ No

Does your bedtime vary a lot ? ☐ Yes ☐ No. If yes, specify :

Do you have difficulty sleeping during the night ? ☐Yes ☐No

If yes,

A. How often do you usually wake up at night? ______
B. How long are these awakenings? ________ (minutes)
C. How many nights per week? ______
D. When falling asleep, do you experience “restless legs” (a feeling of crawling, aching or inability to keep legs still)? ☐ Yes ☐ No
E. Is your sleep disturbed by noise / choking sensation / heartburn / breathlessness / pain / having to urinate / feeling hungry / restless legs / leg cramps / palpitations / other ________________?
F. How do you sleep away from home? ☐ Same ☐ Better ☐ Worse
G. Is your sleep habits same on weekdays and weekends? ☐Yes ☐ No
H. Have you ever taken prescription / over the counter sleeping pills? ☐ Yes ☐ No
   If so, which one(s)? ___________________________
   Was it of help? ☐ Yes ☐ No
I. What other treatments have you tried to help with your sleep?

Have you ever been told that while asleep you
Snore? ☐ Yes ☐ No
Quite breathing? ☐ Yes ☐ No
Thrash about / have excessive leg jerking movements? ☐Yes ☐No
Walk? ☐ Yes ☐ No
Grind your teeth? ☐ Yes ☐ No

Patient Name ___________________________________

Do you experience night sweats? ☐ Yes ☐ No

What time do you usually wake up? ________ : __________

Do you use an alarm clock to awaken yourself? ☐ Yes ☐ No

When you wake up do you

feel refreshed ? ☐ Yes ☐ No

experience headaches ? ☐ Yes ☐ No

Are you experiencing

Tiredness? ☐ Yes ☐ No

Memory lapses? ☐ Yes ☐ No

Difficulty concentrating? ☐ Yes ☐ No

Muscular weakness in emotional situations such as laughter, anger etc? ☐ Yes ☐ No

Body aches / Joint pain? ☐ Yes ☐ No

Do you fall asleep when you are trying not to? ☐ Yes ☐ No

If yes, then

Have you ever fallen asleep while driving an automobile? ☐ Yes ☐ No

If yes, how often do you actually fall asleep while driving? Check one only.

7 days a week __________
4-6 days a week __________
1-3 days a week __________
1-3 days a month __________
less than one day a month or never __________

How many work accidents / car accidents / "near misses" have you had because of excessive sleepiness in the past 5 years? ________

What is your Collar / Neck Size? ___________ (inches)
Employed: ☐ Yes ☐ No
Work hours: _______: _______ to: _______
Shift Work: ☐ Yes ☐ No. If yes, explain:

Current Medications (including those used for sleeping)

Medication	Specify
Prescription (Dose & Frequency)	
Non-Prescription	
Oxygen Therapy (how much, continuous/nightly, name of home care company)	

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Patient Name ___________________________________

Specify if **you or your family members** ever had the following :

Disease	No	Yes	If yes, please explain
Asthma / Chronic Lung Disease			
Thyroid Problems			
Seizures / Epilepsy			
Broken Nose			
Nasal Sinus Problems			
Unusual Dental Problems			
High Blood Pressure			
Heart Disease			
Stroke			
Diabetes			
Depression			
Psychiatric Treatment			
Gained weight			
Menstrual Irregularities			
Impotence			

Have you ever **used** any of the following :

	No	Yes	
Caffeine (Coffee, tea, soda etc.)			
Alcohol			
Cigarettes			
Street Drugs (Marijuana, “uppers”, “downers”, narcotics, hallucinogens, cocaine)			
Other			

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Patient Name : ______________________________

Date : ______________________________

Age : ______________________________

Sex : ______________________________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired ? Please use the following scale to choose the most appropriate number in each situation.

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Change of Dozing
3 = High Chance of Dozing

Situation	**Chance of Dozing**
Sitting and Reading	
Watching TV	
Sitting, inactive in a public space (eg. a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total (numerical value)	