Merrimack Valley Sleep Center, PLLC

49 Atwood Road, Suite #3 Pelham, NH
03076

Phone (603) 635-7711 Fax (603) 635-7722

The answers you provide to the following questions are important. Check all statements that apply to you. Please respond carefully and completely.

Today's date: _____/_____/____ Name: _____ Age: _____

1. I was referred for this sleep test because of:
   - □a. excessive sleepiness/fatigue
   - □b. loud snoring
   - □c. pauses in breathing during sleep
   - □d. insomnia
   - □e. leg jerks during sleep
   - □f. other: _____

2. My sleep problem began when I was _____ years old.

3. My life and daily activities are disrupted by:
   - □a. dozing when I should be awake
   - □b. awakening unrefreshed
   - □c. trouble maintaining attention because of sleepiness
   - □d. worries about my sleep
   - □e. other:_____

4. My sleep problem is: □a. serious
   - □b. moderate
   - □c. mild
   - □d. inconsequential

5. I had an evaluation, examination, or treatment for a sleep problem in _____

5a. my diagnosis was:
   - □a. periodic limb movement's disorder
   - □b. obstructive sleep apnea syndrome
   - □c. other

6. □a. On workdays, I usually try to fall asleep at: _____. am / pm
   - □b. On workdays, I usually try to awaken at: _____. Am / pm
   - □c. On workdays, I usually get out of bed at: _____. Am / pm

7. □a. On non-workdays, I usually try to fall asleep at: _____. am / pm
   - □b. On non-workdays, I usually try to awaken at: _____. Am / pm
   - □c. On non-workdays, I usually get out of bed at: _____. Am / pm

8. □a. It takes me more than 30 minutes to fall asleep: _____day(s) of the week.
□b. It takes me more than 60 minutes to fall asleep: _____day(s) of the week.

9. Often, when I am trying to fall asleep, I
□a. have racing thoughts/worry
□b. feel sad
□c. feel unable to move
□d. see vivid dream-like images
□e. feel abnormal sensations (crawling, aching, twitching, etc.) of my legs so that I feel that I must move them
□f. have pain in my: 1) head; 2) back; 3) chest; 4) belly
□g. sleep with someone in my room
□h. sleep with someone in my bed
□i. get up to attend my children

10. Often, when I am awakening, I

□a. feel unable to move	□i. am frightened
□b. see vivid dream-like images	□j. have dreams
□c. suddenly feel very alert	□k. have nightmares
□d. feel my heart pounding	□l. have headaches
□e. sweat excessively	□m. am nauseous
□f. attend to my children	□n. have dry mouth
□g. am confused	□o. awaken more than an hour too early □h. scream

11. On a typical night, I sleep _____hours.

12. It usually takes me (fill in amount of time) _____ hour's minutes to fall asleep.

13. During the minutes before attempting to sleep I usually:

□a. watch TV	□f. Eat
□b. listen to music	□g. drink
□c. read	□h. have sex
□d. speak with my spouse/partner	□i. quarrel □e. plan or
worry	□j. other:

14. During a month, my total sleep per 24-hour day varies from a minimum of _____hours to a maximum of _____hours.

15. During a typical night I awaken (how many?) _____ Times.

16. During a typical night my longest period of remaining awake without sleeping is _____ hour's ____ minutes.

17. After falling asleep, I am most likely to awaken: □a. During the first half of the night.

□b. During the second half of the night.

□c. At various times.

□d. I seldom awaken during the night.

18. My sleep is frequently disturbed by:

□a. heat □h. thirst

□b. cold □i. need to urinate

□c light □j. noise

□d. movement of my bed partner □k. shortness of breath

□e. coughing □l. indigestion, gas

□f. choking □m. nightmares

□g. hunger □n. chest pain □o. heartburn

19. When I sleep, I often:

□a. have restless disturbed sleep □e. have unusual movements

□b. snore loudly □f. urinate in my bed

□c. walk in my sleep □g. grind my teeth

□d. fall out of bed □h. bite my tongue

20. During a month my awakening time varies from the earliest of _____ am / pm to the latest of _____ am / pm.

21. During a typical week I nap _____times.

If I nap, my usual nap is (how long?) _____ minutes _____ hours if I nap,

my naps are refreshing? □ Yes □ No

22. When I laugh, I am surprised, angry, or excited, then my muscles may twitch or give way. □ Yes □ No

23. How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? *(This question refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you.)*

Use the following scale to assign the most appropriate number for each situation listed.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	*Chance of Dozing*
a. Sitting and reading	_____
b. Watching TV	_____
c. Sitting inactive in a public place (e.g., a theater or a meeting)	_____
d. As a passenger in a car for an hour without a break	_____
e. Lying down to rest in the afternoon when circumstances permit	_____
f. Sitting and talking to someone	_____
g. Sitting quietly after a lunch without alcohol	_____
h. In a car, while stopped for a few minutes in traffic	_____

24. Does anyone in your family have a sleep problem? If so, please describe:

Relationship to you	Problem
_____	_____
_____	_____
_____	_____

25. On a typical day I drink:

	During a typical day	within two hours before bedtime
a. caffeinated coffee	_____ cups	_____ cups
b. caffeinated tea:	_____ cups	_____ cups
c. caffeinated soda	_____ cups	_____ cups
d. beer	_____ glasses	_____ glasses
e. wine	_____ glasses	_____ glasses
f. other alcohol drinks	_____ glasses	_____ glasses

26. During a typical 24 hour day I smoke:

□a. less than one pack of cigarettes

□b. _____ pack(s) of cigarettes

□c. cigars

□d. pipe bowls

□e. I don't smoke any tobacco products.

27. I use: Never Sometimes Often

a. Marijuana? □a. □b □c.

b. Narcotics (cocaine, crack, heroin, morphine, opium, etc.)? □a. □b □c. c. hallucinogens

(LSD, mescaline, angel dust, mushrooms, etc.)? □a. □b □c. D.

stimulants (uppers)? □a. □b □c.

E. depressants (downers)? □a. □b □c.

28. Please print the name and doses (in mg.) of all medications you take now or have taken within the last ten days.

Print clearly and accurately. Print the name of each medication. as shown on each label. Note dosage and frequency. A misspelling can affect your diagnosis.

Name	Dose	What for?

29. I have taken these medications to treat insomnia or to help me stay awake:

Name of medicine	did it help?
_____	□Yes □No
_____	□Yes □No
_____	□Yes □No
_____	□Yes □No
_____	□Yes □No

30. I participate in an athletic activity or other exercise:

□a. rarely or never

□b. one time per week.

□c. two times per week.

□d. three times per week.

□e. four times per week.

□f. five or more times per week.

31. My usual working hours are from to _____ am/pm to _____ am/pm

32. What do you think causes your sleep/wake problem?

33. My current weight is _____lbs. The heaviest I ever weighed was _____pounds.

34. My weight has

□a. Increased □b. Decreased recently.

If it has changed, then please explain:

35. My height is _____ (in inches).

36. My health problems include:

□a. angina
□b. heart attack
□c. heart failure
□d. high blood pressure
□e. lightheadedness or fainting
□f. headaches
□g. ringing my ears
□h. seizures
□i. impotence
□J. back pain
□k. neck pain
□1. Frequent urination
□p. lung disease
□q. stomach upset
□r. intestinal disturbance
□s. emotional problems
□t. mental problems
□u. muscle cramps
□v. neuropathy
□w. diabetes
□x. thyroid dysfunction
□r. arthritis
□z. limb pain
□aa. Bronchitis

□m. urinary infections	□bb. Depression
□n. asthma	□cc. anxiety
□o. allergies	□dd. other: _____

37. Do you have trouble swallowing? □YES □NO

38. Have you had your tonsils and/or adenoids removed? □YES □NO
If yes, when? _____

39. Over the past year I have been hospitalized for the following problems:

Month	Reason for hospitalization	Surgery?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The remaining questions should be answered by your bed-partner or sleep observer.

Name of the patient's sleep observer:

_____

Please print

I. I have observed the patient sleeping:

□a. once or twice

□b. a few times

□c. often

II. I have observed the patient doing the following during sleep or awakening:

□a. snoring lightly

□b. snoring loudly

□c. snorting

□d. choking

□e. pauses in breathing

□f. twitching/kicking of legs (asleep)

□g. twitching/kicking of arms (asleep)

□h. grinding teeth (asleep)

□i. walking (asleep)

□j. doing semi-purposeful activity (asleep)

□k. sitting up in bed (while asleep)

□1. Awakening complaining of pain

□m. (head rocking or banging (asleep)

□n. getting out of bed (while asleep)

□o. biting tongue

□p. becoming rigid and/or shaking

□q. crying out

□r. talking (asleep)

□s. bed wetting

□t. other: _____

Describe the sleep behavior checked above. Include a description of the activity, the time during the night when it tends to occur, how frequently it occurs, and how often it occurs over the course of days, weeks, months, or years.

_____

_____

_____

_____

III. Has the patient fallen asleep during normal day or evening activities or in dangerous situations? □Yes □No If Yes please describe:

_____