

OVERVIEW OF SLEEP PROBLEMS

1. Why are you seeking treatment at this time?

SLEEP ENVIRONMENT

2. Is there any aspect of your sleep environment that seems to contribute to your sleep problem? Yes No
3. Are you bothered by the lighting conditions of your bedroom during sleep? Yes No
4. Is your bedroom too hot or too cold during sleep? Yes No
5. Is your bedroom too humid or too dry? Yes No
6. Are you bothered by noise during sleep? Yes No
7. Is your bed or bedding uncomfortable? Yes No
8. Do you sleep with anyone else in the same room or the same bed? Yes No
- If yes, are you bothered by your roommate's or bed partner's snoring or movements during sleep? Yes No
- If yes, do you sleep in the same room or same bed with your children? Yes No
9. Do you sleep in the same bed with a pet? Yes No

SLEEP HABITS

10. What is your usual bedtime (the time you get into bed)? _____ AM / PM
11. What is your usual rise time (the time you get out of bed)? _____ AM / PM
12. Does your bedtime and rise time fluctuate from day to day? Yes No
13. Do you change your bedtime and rise time on the weekends or on days that you do not work? _____ AM / PM
- If yes, what is your usual bedtime on weekends or non-work days? _____ AM / PM
- If yes, what is your usual rise time on weekends or non-work days? _____ AM / PM
14. How long does it usually take you to fall asleep after you get into bed? _____ mins
15. How many times do you usually awaken during the sleep period? _____ times
16. What is the average duration of your awakenings? _____ mins
17. On average, how long would you say you actually are asleep each night? _____hrs _____mins
18. Do you have a regular, nightly routine that you follow every night before getting into bed? Yes No
- If yes, what do you usually do? _____
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19. Do you read, watch television, or engage in other activities while in bed before sleep onset? Yes No
20. Do you usually eat before getting into bed, or while in bed before sleep onset? Yes No
21. Do you tend to "watch the clock" before or during your sleep period? Yes No

DAYTIME FUNCTIONING

22. Do you usually feel sluggish, sleepy, or fatigued upon awakening in the morning? Yes No
23. Do you usually feel fatigued throughout the day? Yes No
24. Are you bothered by low mood, irritability, or anxiety during the day? Yes No
25. Are you bothered by problems with attention, concentration, or memory during the day? Yes No
26. Do you find it hard to persist at things you are doing, even simple things? Yes No
27. Do you have difficulty functioning in social situations due to fatigue? Yes No
28. Do you have difficulty functioning at work due to fatigue? Yes No
29. Are you usually bothered by sleepiness during the day? Yes No
30. Do you feel that you've lost motivation to do things, or that you've lost interest or pleasure in activities that you used to enjoy? Yes No
31. Has your sex drive (libido) diminished? Yes No
32. Have you been eating less than usual, or have you recently lost weight? Yes No
33. Have you been eating more than usual, or have you recently gained weight? Yes No
34. Do you tend to fall asleep in sedentary situations (for example, while watching television, working at a computer, in meetings)? Yes No
35. Do you fall asleep when in a warm room? Yes No
36. Do you tend to fall asleep at inappropriate times? Yes No

If yes, please give an example: _____

37. Has your sleepiness or falling asleep ever put you or someone else in danger? Yes No
38. Have you had a motor vehicle accident due to sleepiness or fatigue? Yes No
39. Do you feel disabled by daytime sleepiness or fatigue? Yes No
40. Do you usually nap during the day? Yes No

If Yes:

How long do you usually nap? _____ minutes

What time of day do you usually nap? Morning / Afternoon / Evening

How many naps do you usually take per day? _____

How many naps do you usually take per week? _____

DIFFICULTY FALLING ASLEEP AND STAYING ASLEEP

41. Do you usually have difficulty falling asleep at the beginning of the sleep period? Yes No
42. Are you bothered by awakenings that occur during the night (after you've fallen asleep)? Yes No
43. Do you wake up too early and find that you can't return to sleep? Yes No
44. If you answered yes to any of the above, are you bothered by the problem? Yes No
45. Does difficulty falling asleep or staying asleep interfere with your daytime functioning? Yes No

SLEEP QUALITY

46. Are you bothered by restless or fitful sleep? Yes No
47. Are you bothered by poor quality sleep? Yes No
48. Do you feel that you sleep too "lightly?" Yes No
49. Do you feel that your sleep is not restful, no matter how much sleep you get?..... Yes No

SNORING AND DIFFICULTY BREATHING DURING SLEEP

50. Do you snore? Yes No
51. Have you been told that you snore loudly, or that your snoring disturbs others? Yes No
52. Have you awakened yourself or someone else with your snoring sounds? Yes No
53. Is snoring a source of distress in your marriage or other significant relationship? Yes No
54. Has anyone ever told you that you seem to have difficulty breathing or that you stop breathing during sleep? Yes No
55. Do you ever awaken with the sensation of shortness of breath? Yes No
56. Do you ever awaken gasping, choking, or "gulping for air?" Yes No
57. Do you often awaken with a dry mouth or sore throat?..... Yes No
58. Do you ever awaken feeling disoriented or confused? Yes No
59. Do you ever awaken with headaches? Yes No
60. Do you use the restroom frequently at night? Yes No
61. Do you experience "acid reflux," "acid indigestion," or dyspepsia? Yes No
62. (Men) Do you have difficulty getting or keeping an erection? Yes No
63. Have you had surgery for snoring or sleep apnea? Yes No
64. Have you been treated for snoring or sleep apnea with a dental device? Yes No
65. Have you been treated for snoring or sleep apnea with nasal CPAP, BiPAP, or Autopap?..... Yes No

NARCOLEPSY

66. Have you ever experienced "sleep attacks" (sudden, irresistible urge to sleep)? Yes No
67. Upon falling asleep or waking up have you ever had the experience of seeing things or hearing things that were not really there? Yes No
68. Upon falling asleep or waking up have you ever had the experience of being unable to Move your arms or legs, even if you try? Yes No
69. Have you ever done things during the day without having awareness of your actions? Yes No
70. Have you ever had a seizure? Yes No
71. Have you ever experienced sudden muscle weakness while awake (In mild conditions this could be experienced as a weak grip, or leg or arm weakness. In severe conditions, one's legs might buckle and the person might fall to the floor) ?..... Yes No
- If yes, was this brought on by an intense emotion? Yes No
72. Do you start dreaming right after you fall asleep? Yes No

SLEEP AND SLEEP-RELATED MOVEMENTS

73. Do you experience painful or unusual sensations of your legs while at rest, especially in the evening? Yes No
74. Do painful or unusual sensations of your legs interfere with your ability to fall asleep? Yes No
75. Do you experience painful or unusual sensation of your legs that awaken you, or that prevent you from returning to sleep if you wake up during your sleep period?..... Yes No
76. If you answered yes to any of the above items, does walking or massage seem to relieve the discomfort in your legs? Yes No
77. Do you ever experience "twitching" or "jerking" of your feet or legs while asleep? Yes No
78. Do your leg movements disturb your bed partner? Yes No
79. Do you notice that your hands and feet are cold prior to, during, or after sleep? Yes No

SLEEP RHYTHMS

80. If employed, what are your usual work hours? Start shift: _____ AM / PM End: _____ AM / PM
81. Are you a shift worker (evenings, nights, or rotating shifts)? Yes No
82. Do you struggle to balance your shift work and family activities? Yes No
83. Do you suffer from jet lag? Yes No
84. Do you find that you typically fall asleep **earlier** than desired and awaken **earlier** than desired?..... Yes No
85. Do you find that you typically fall asleep **later** than desired and awaken **later** than desired? Yes No

PARASOMNIAS

86. Please indicate if you have experienced the following symptoms at any time. Please note the age that symptoms began and your age when they stopped. Place a checkmark in the column at the right to indicate an ongoing problem.

Problem Behavior	Check "yes" if past or current problem	Frequency/ week	Age when symptoms began	If stopped, age when last occurred	Ongoing problem?
Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleepwalking associated with "night eating"	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleepwalking associated with injury to self/others	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Nightmares	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Terrors	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bed Wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing during sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Sudden unusual movements during sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep talking	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (describe):	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL STATUS AND HISTORY

87. Have you now, or have you ever in the past, received treatment for high blood pressure? Yes No
88. Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? Yes No
89. Have you ever suffered a stroke? Yes No
90. Have you ever suffered a heart attack? Yes No
91. Have you been told that you have GERD (gastroesophageal reflux disease), acid indigestion, or dyspepsia?..... Yes No
If yes, why? _____
92. Have you ever been hospitalized for any reason? Yes No
93. Have you ever had surgery? Yes No
If yes, why? _____
94. Have you ever had a serious injury? Yes No
If yes, why? _____

95. Please complete the following checklist by identifying medical conditions that you have now or have had in the past:

System	Type of problem	Date problem began	Ongoing or indicate date stopped
Head, eyes, ears			
Nose			
Sinuses			
Mouth and throat			
Lungs and chest (COPD)			
Heart (Heart attack, high blood pressure)			
Central nervous system (e.g., headaches, seizures)			
Digestive system (e.g., GERD)			
Musculoskeletal system			
Endocrine system (e.g., over-weight, diabetes, etc.)			
Skin			
Allergies (specify to what)			
Psychiatric			
Other			

MEDICATION USE

96. Please list all prescription and over-the-counter medications that you currently use.

Medication Name	Dose (if known)	Number Pills Taken per Day (if use is less than daily please indicate frequency of use)	Reason Used	Check Here if Medication is Used to Treat a Sleep Problem	Effectiveness	Prescribing Doctor

FOOD, BEVERAGES AND OTHER SUBSTANCES

97. For each beverage listed, indicate the average number of ounces you drink per day:

- Regular coffee _____
- Regular tea _____
- Cola _____

98. Do you usually drink caffeinated beverages (coffee, tea, cola) within 6 hours before bedtime? Yes No

99. Do you drink caffeinated beverages during the day to help you stay awake? ? Yes ? No
100. On average, do you consume more than 5 alcoholic drinks per day? ? Yes ? No
101. On average, do you consume more than 15 alcoholic drinks per week? ? Yes ? No
102. Do you drink alcohol (beer, wine, or hard liquor) shortly before bedtime? ? Yes ? No
103. Do you use alcohol to help you fall asleep? ? Yes ? No
104. Do you smoke cigarettes? ? Yes ? No
 If yes, how many cigarettes do you smoke per day? _____
 Do you smoke just before bed, or if you happen to awaken during your sleep period? _____
105. Do you smoke cigars or a pipe? ? Yes ? No
106. Do you use any illicit drugs (e.g., marijuana, cocaine, crack)? ? Yes ? No
107. Do you use any illicit drugs to help you fall asleep or stay asleep, or stay awake? ? Yes ? No

FAMILY AND SOCIAL HISTORY

108. Father's age: _____ If deceased, what was the year and cause of death? _____
109. Mother's age: _____ If deceased, what was the year and cause of death? _____
110. Number of siblings: _____ Ages of your children: _____
111. Does anyone in your family have any sleep problems? ? Yes ? No
 If so, briefly describe and give their relationship to you: _____
112. Does anyone in your family have a history of serious medical or psychiatric problems? ? Yes ? No
 If so, what is their problem and what is their relationship to you? _____
113. Is there any additional information regarding your sleep, medical, or family histories that you would like to add?

Thank you for completing the Sleep Disorders Inventory[®]. The information that you have provided will assist your doctor in evaluating and treating your sleep complaint. If you have completed this questionnaire in your primary care doctor's or specialist's office, you should review your answers with the doctor. You also may ask your doctor to submit your questionnaire to the Clinilabs Sleep Disorders Institute for review. Please use the e-mail or the street address indicated below for all correspondence. If you have completed this questionnaire at the Sleep Disorders Institute, you may request a copy for your files or your doctor's medical record.

Your health is our first concern. For more information about sleep and sleep disorders, please visit www.getsleepfacts.com. For information about Clinilabs and its affiliates, you may visit our corporate Web site at www.clinilabs.com. Please submit inquiries to info@clinilabs.com.

Please return all completed questionnaires to: Clinilabs, Inc.
 Sleep Disorders Institute
 423 W. 55th Street, 4th Floor
 New York, New York 10019

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