

Screening Questionnaire

QUESTIONNAIRE I: To be completed by the patient.

Name: _____
Age: _____ Sex: _____ Height: _____ Weight: _____
Address: _____

Email address: _____
Telephone: (_____) _____
Your doctor's name and address: _____

A. What complaints do you have related to sleep?

1. Sleepiness/fatigue
 Fall asleep at the wrong times.
2. Awakenings with:
 snores or snorts
 throat closed off
 Dry throat
 Sour/bitter taste or heartburn
 Headaches
 chest pain/palpitations
 Shortness of breath
 Panic
3. Insomnia:
 Can't fall asleep initially
 Wake up too early
 Light, fragmented or unrefreshing sleep

B. Have others observed your sleep or levels of alertness? (Y/N)

If so, have they noted you:

- Snore badly
- Stop breathing
- Thrash while asleep
- Scream out in sleep
- Convulse
- Act out dreams
- Walk/ run in sleep
- Leg/body jerks
- Are too sleepy
- Fall asleep driving
- Stare or go blank

C. Have you experienced:

- Falling asleep at the wheel
- Sleep related accidents/near misses
- Confusion while driving
- Drive on "autopilot"/ no recall of trip
- Dream in brief naps
- See/ hear things when drowsy
- Abrupt paralysis when first dozing off or awakening
- Sudden loss of muscle strength provoked by emotions
- Night sweats
- Have to get up frequently to urinate
- Bedwetting after age 6
- Vomiting in sleep
- Bite tongue
- Memory loss, confusion
- Fibromyalgia
- Chronic fatigue
- Episodic impaired awareness, staring, unreality feelings
- Abnormal smells or tastes, always identical & unexplained
- Visual distortions not due to eye problems
(objects look too large or small or distorted in shape)

D. Have you had any of the following illnesses?

- High blood pressure
- Epilepsy/seizures
- Stroke
- Chronic lung disease (ex: asthma, emphysema, "COPD")
- Heart trouble (ex: coronary disease, heart attack, heart failure, abnormal heart rhythms)

QUESTIONNAIRE II: To be completed by a family member, co-worker, friend or others who have observed the patient's sleep and alertness.

Name: _____
Relationship to patient: _____
Email address: _____
Telephone: (_____) _____

A. How often have you observed the patient's sleep?
 frequently occasionally rarely never

B. Which of the following describes your situation?

- visit patient live with patient share same bed
- sleep in same bedroom sleep in other room
- I sleep lightly I sleep soundly

C. If you cannot share bedroom with patient, why?

- patient snores patient thrashes or kicks in sleep
- patient flings arms or acts out dreams
- own sleep problem
- other: _____

D. Snoring or breathing abnormalities:

- patient stops breathing
- patient snores loudly frequently
 irregularly w/ gasps
- patient turns blue/dusky
- patient struggles to breathe
- I've prodded/ shaken patient to stimulate breathing

E. Other events I've noted as the patient sleeps:

- sitting/ standing up frantic behaviors
- gasping/ choking vomiting bedwetting
- generalized shaking/ jerking eyes roll up
- screaming out walking or running

F. Events in wakefulness: memory loss/ confusion

- falls asleep inappropriately
- seems unaware of own sleepiness
- dozes off while driving standing working
- personality change, irritability or depression
- episodes of going blank/ staring when not sleepy
- seizures or convulsions sudden falling
- muscle weakness with emotions
- episodes of panic

Return completed questionnaires to:

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We will review your responses

free of charge and share our impressions with you promptly.