



Sleep Evaluation

Name: _____ Date: _____ Age: _____

Neck Size: _____ Height: _____ Weight: _____ Sex: M _____ F _____

My chief complaint is: _____

Please check the appropriate answer:

1. Do you snore? Yes No I don't know

If "yes" please continue with question 2. If "no" or "I don't know" please skip to question 6.

2. Your snoring is: Softer than talking As loud as talking Louder than talking

3. Your snoring occurs: every/almost every night A few times a week Once or less a week

4. Your snoring is: Frequently interrupted by pauses or choking Occasionally interrupted by pauses or choking

Not interrupted as far as I know

5. Do you snore in every body position? Yes No I don't know

6. Do you have, or have you ever had a bed partner: Yes No

If "yes" please continue with question 7. If "no" please skip to question 10.

7. Has your bed partner ever said that you have pauses in your breathing or periods of stopped breathing during your sleep?

Yes No

8. Has your bed partner ever commented that you snore? Yes, loud snoring Yes, soft snoring No

9. If you snore, is it loud enough to bother her/him? Yes No

10. Has anyone besides a bed partner ever commented on your snoring (roommate, neighbor, family, etc.)

Yes (loud) Yes (soft) No

11. Do you feel fatigued, exhausted, tired or not up to par?

3 or 4 times a day

Nearly every day

Once or twice a week

Once or twice a month

Never or hardly ever

12. Do you feel that in some way your sleep is not refreshing or restful?

3 or 4 times a day

- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

13. Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?

- 3 or 4 times a day
- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

14. Do you wake up during the night or in the morning with headaches? Yes No

15. When falling asleep or waking up do you feel paralyzed? Yes No

16. Do you dream or hallucinate as you fall asleep? Yes No

17. Do you feel weakness in response to anger, laughter or surprise? Yes No

18. Are you a shift worker? Yes No

19. Do you have trouble initiating and/or maintaining sleep?

- 3 or 4 times a day
- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

20. What do you feel is your ideal amount of sleep per day? 2-3 hrs 5 6 7 8 9 10+

21. Estimate the average number of hours of sleep you have per day. 2-3 hrs 5 6 7 8 9 10+

Answer by circling a number from 1 to 5. If you strongly disagree with the statement or it never happens to you circle 1. If the statement is always true in your case or you agree strongly with it circle 5. You may also choose 2 (rarely), 3 (sometimes), or 4 (usually) as the answer.

- | | | | | | |
|--|---|---|---|---|---|
| 22. When falling asleep, I feel paralyzed (unable to move) | 1 | 2 | 3 | 4 | 5 |
| 23. I get too little sleep at night | 1 | 2 | 3 | 4 | 5 |
| 24. I often have a poor night's sleep | 1 | 2 | 3 | 4 | 5 |
| 25. I have trouble getting to sleep at night | 1 | 2 | 3 | 4 | 5 |
| 26. I wake up often during the night | 1 | 2 | 3 | 4 | 5 |
| 27. My bedtime varies a lot | 1 | 2 | 3 | 4 | 5 |
| 28. At bedtime, thoughts race through my mind | 1 | 2 | 3 | 4 | 5 |
| 29. At bedtime, I feel sad and depressed | 1 | 2 | 3 | 4 | 5 |
| 30. At bedtime, I worry about things | 1 | 2 | 3 | 4 | 5 |

Previous illnesses:

Name of illness

Year of onset

| Name of illness | Year of onset |
|-----------------|---------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Beck Inventory: *Read each item below carefully and circle the number next to the answer that best describes how you have been feeling the past few days.*

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't even cry even though I want to.
11. 0 I am no more irritated by things than I ever am.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time now.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.
14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.
15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get tired more than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.
20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches or pains, or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

I was initially motivated to come to this clinic by my

Physician

Myself

Family member

Friend

Other comments (spouse) _____