Nor-Lea Sleep Questionnaire

Your Name: _____AGE: _____

Describe in detail what your sleep problem is: _____
_____
_____
_____

How long has it been a problem? _____

Do you now have or have you ever had:

High Blood Pressure	Yes / No
Sinus problems	Yes / No
Allergies	Yes / No
Heart problems	Yes / No
Stroke	Yes / No
Tonsillectomy	Yes / No
Nasal fracture	Yes / No
Nasal surgery	Yes / No
Diabetes	Yes / No

List all other MEDICAL PROBLEMS:	How long?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

QUESTIONNAIRE
(Continued)

List All Medications:	Dosage & How Often Taken	Doctor who Prescribed Medication

Are you currently using Supplemental Oxygen at home Yes/No

SURGICAL HISTORY

Procedure: _____
Date: _____ **Surgeon's Name:** _____

Procedure: _____
Date: _____ **Surgeon's Name:** _____

Procedure: _____
Date: _____ **Surgeon's Name:** _____

Procedure: _____
Date: _____ **Surgeon's Name:** _____

Procedure: _____
Date: _____ **Surgeon's Name:** _____

Procedure: _____
Date: _____ **Surgeon's Name:** _____

List ALL Medication Allergies:

_____
_____
_____
_____

QUESTIONNAIRE
(Continued)

SLEEP HISTORY:

Usual bedtime on weekdays / workdays: _____
Usual length of time to fall asleep: _____
Usual wake up time: _____
Average number awakenings in the night: _____
Average total sleep time: _____
Do you feel refreshed or restored in the morning? Yes / No
Do you nap during the day? Yes / No
If yes, number of naps: _____
Duration of naps: _____
Are naps refreshing? Yes / No

Usual bedtime on weekends / days off: _____
Usual wake up time: _____
Total sleep time per 24 hour day off: _____

How many hours of sleep do you need to feel rested? _____

SOCIAL HISTORY:

Have you ever smoked? Yes / No
If yes, for how many years? _____
Average number of packs per day _____
Have you quit smoking? Yes / No
How long ago? _____

What is your present occupation? _____
What are your work hours? _____
Do you drink caffeinated beverages (coffee, tea, soda)? _____
If yes, how much per day? _____
Do you drink alcoholic beverages? _____
If yes, how much per day? _____
Do you get regular exercise? How often? _____
Do you have any unusual eating habits? _____

SLEEP ENVIRONMENT:

Do you read in bed?	Yes / No
Do you watch TV in bed?	Yes / No
Do you share the bed with anyone?	Yes / No
Does your partner have a sleep disorder?	Yes / No
Do you have pets in the bedroom?	Yes / No
What is the temperature in your bedroom?	_____

FAMILY HISTORY

Marital status: **Single Married Divorced Separated Widowed**

Number of Children_____

Age: _____ Health_____
Age: _____ Health_____
Age: _____ Health_____
Age: _____ Health_____
Age: _____ Health_____
Age: _____ Health_____

Mother: Living: Yes / No, Age: ____ Health_____

Father: Living: Yes / No, Age: ____Health _____

Number of **Brothers**: _____
Age: _____ Health _____
Age: _____ Health _____
Age: _____ Health _____

Number **of Sisters**: _____
Age: _____ Health _____
Age: _____ Health _____
Age: _____ Health _____

Do any members of your family have sleep problems? If so, please describe: _____
_____
_____

Now that you have completed our questionnaire, do you have any other comments you would like to add?

_____
_____
_____

Please answer the following questions on a scale from 0 to 4:

0=not at all **2=moderate** **4=Very great**

1.	How great a problem do you have with sleepiness, (feeling sleepy, struggling to stay awake during the daytime)?	0	1	2	3	4
2.	How great a problem do you have with fatigue, (tiredness, exhaustion, lethargy, even when you are not sleepy)?	0	1	2	3	4
3.	How much trouble do you have falling asleep at night?	0	1	2	3	4
4.	Do you snore?	0	1	2	3	4
5.	Do you hold your breath or stop breathing in your sleep?	0	1	2	3	4
6.	Do you have gas, indigestion, or heartburn at night?	0	1	2	3	4
7.	Do you have night sweats?	0	1	2	3	4
8.	Do you wake up with a headache in the morning?	0	1	2	3	4
9.	Do you wake up with a dry mouth?	0	1	2	3	4
10.	Do you have trouble breathing through you nose?	0	1	2	3	4
11.	How many times a night do you wake up to urinate?	0	1	2	3	4
12.	Do you have difficulty breathing while lying down flat?	0	1	2	3	4
13.	Do you have shortness of breath with exertion?	0	1	2	3	4
14.	Do you have choking with meals?	0	1	2	3	4
15.	When you awaken from sleep, do you ever feel paralyzed, unable to move even though you are awake?	0	1	2	3	4
16.	When someone startles you or makes you laugh, do you get weak, fall, or do your knees buckle?	0	1	2	3	4
17.	While in the process of <u>falling</u> asleep, do you have vivid dreams or hallucinations?	0	1	2	3	4
18.	Do you have frequent uncontrollable bouts of sleep, sleep attacks, an irresistible urge to sleep?	0	1	2	3	4
19.	Do you wake up gasping or short of breath?	0	1	2	3	4

20.	Do your legs kick or twitch frequently during the night?	0	1	2	3	4
21.	Do you have restless legs (crawling, itching, or aching, an inability to keep your legs still)?	0	1	2	3	4
22.	Do you have problems with memory or concentration?	0	1	2	3	4
23.	Problems with impotence or lack of sexual interest?	0	1	2	3	4
24.	Are you irritable?	0	1	2	3	4
25.	Do you feel depressed?	0	1	2	3	4
26.	Do you feel anxious?	0	1	2	3	4
27.	Do you grind your teeth at night?	0	1	2	3	4
28.	Do you have to fight sleep while driving?	0	1	2	3	4
29.	Have you ever had a car wreck caused by sleepiness?	0	1	2	3	4

The Epworth Sleepiness Scale

Name _____

Date _____ / _____ / _____ **Age _____** **Sex _____**

How likely are you to dose off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of Dozing**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes	0	1	2	3

Total _____