

**Advocate Lutheran General Hospital**  
**Sleep Disorder Center**  
**Parkside Professional Building**  
**1775 Dempster Street**  
**Park Ridge, IL 60068**  
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**Advocate Medical Group**  
**Sleep Disorder Center**  
**825 East Golf Road**  
**Arlington Heights, IL 60005**  
**Phone 847- 640-9180 Fax 847-640-4450**

## **Sleep Disorder Center Patient Questionnaire**

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Marital Status: (circle one) married / significant other / single / divorced / widowed

List number of children and their ages:

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Occupation: \_\_\_\_\_ Years of Education: \_\_\_\_\_

Hours that you work: \_\_\_\_\_ Days that you work: \_\_\_\_\_

Does your current job involve shift work?            YES            NO

Do you (or have you ever) worked the night shift (e.g. 11pm - 7:30am)?            YES            NO

### ***General Information***

Who referred you to the Sleep Disorder Center? \_\_\_\_\_

Why were you referred to the Sleep Disorder Center?

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How much sleep do you feel you need in order to function well the next day? \_\_\_\_\_ hrs \_\_\_\_\_ min

**Please indicate the extent to which you have a problem with the following items below.  
(Circle situations that apply)**

	Never		Occasionally		Always
With falling asleep or staying asleep	1	2	3	4	5

Feeling sleepy or struggling to stay awake in the daytime?	1	2	3	4	5
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With fatigue, tiredness, exhaustion or lethargy even when you are NOT sleepy?	1	2	3	4	5
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With not feeling refreshed, no matter how much you sleep?	1	2	3	4	5
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Have you had any previous evaluations, examinations or other problems with sleep?

YES                      NO

If yes, briefly describe the evaluation, treatment, and results:

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What factors make your sleep problem worse: (e.g., stress at work, travel plans, etc.)? \_\_\_\_\_

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What factors improve your sleep? (e.g., vacation, sex, etc.)

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When was the last period in your life that sleep was not a problem?

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### ***Bedtime & Wake Up***

- What is your usual bedtime on weekdays? \_\_\_\_\_ am/pm
- What time do you get out of bed? \_\_\_\_\_ am/pm
- How long does it usually take you to fall asleep after the lights are off? \_\_\_\_\_ minutes
- On average, how many times do you awaken during the night? \_\_\_\_\_ times

- On a typical night, how long do you spend awake in the middle of the night (total number of minutes for all awakenings)? \_\_\_\_\_minutes
- What is the total number of hours of sleep that you usually get on weekdays (work days)? \_\_\_\_\_hrs\_\_\_\_\_min
- On weekends (non-work days), do you keep the same sleep-wake schedule? YES NO
- If no, please describe: Bedtime \_\_\_\_\_am/pm Wake-up \_\_\_\_\_am/pm

### ***Sleep Related Symptoms***

The following questions pertain to symptoms you may experience JUST PRIOR to falling asleep, DURING sleep or UPON AWAKENING.

#### **How often do you:**

	Never	Monthly	Nightly
• Experience crawling or aching leg sensations and inability to keep legs still?	1	2	3 4 5
• Have leg cramps (“Charlie Horses”)?	1	2	3 4 5
• Experience leg jerks while you are asleep?	1	2	3 4 5
• Awaken screaming, violent and confused?	1	2	3 4 5
• Have disturbing dreams?	1	2	3 4 5
• (Just prior to falling asleep or right after waking up) Experience vivid, dreamlike scenes even though you know that you are awake?	1	2	3 4 5
• Experience weakness or paralysis just before falling asleep or upon awakening?	1	2	3 4 5

### ***During the Day***

- Have you ever experienced sudden bodily weakness and/or fallen asleep? YES NO
- If yes, were you aware of your surroundings? YES NO
- Was this brought on by any particular feeling or event? YES NO

## *During Sleep*

Never      Monthly      Nightly

### **Do You:**

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| • Snore?   | 1 | 2 | 3 | 4 | 5 |
| • Hold your breath or stop breathing while asleep?   | 1 | 2 | 3 | 4 | 5 |
| • Suddenly wake up gasping for breath or unable to breathe?  | 1 | 2 | 3 | 4 | 5 |
| • Notice that your heart pounds, beats strongly or Irregularly?  | 1 | 2 | 3 | 4 | 5 |
| • Sweat?   | 1 | 2 | 3 | 4 | 5 |
| • Awaken in the morning with a headache?   | 1 | 2 | 3 | 4 | 5 |
| • Have nasal congestion?   | 1 | 2 | 3 | 4 | 5 |
| • Breathe through your mouth while you are asleep?   | 1 | 2 | 3 | 4 | 5 |
| • Experience any kind of pain or physical discomfort?  | 1 | 2 | 3 | 4 | 5 |
| • Have chest pain?   | 1 | 2 | 3 | 4 | 5 |
| • Have a persistent cough that disturbs your sleep?  | 1 | 2 | 3 | 4 | 5 |
| • Experience “gas” in your stomach , indigestion, or heart burn upon awakening?                              | 1 | 2 | 3 | 4 | 5 |
| • Experience regurgitation or burning in the throat, choking or gagging on stomach contents, upon awakening? | 1 | 2 | 3 | 4 | 5 |
| • Grind your teeth while asleep?   | 1 | 2 | 3 | 4 | 5 |
| • Sleep with someone else in your bed?   | 1 | 2 | 3 | 4 | 5 |
| • Have restless, disturbed sleep?  | 1 | 2 | 3 | 4 | 5 |
| • Disturb the sleep of your bed partner?   | 1 | 2 | 3 | 4 | 5 |
| • Depend on an alarm clock to wake up?   | 1 | 2 | 3 | 4 | 5 |
| • Notice that you are unusually difficult to wake up in the morning?   | 1 | 2 | 3 | 4 | 5 |

## *Daytime Functioning*

During the past six months, have you EITHER fallen asleep without intending to (sleep attacks), OR struggle to stay awake (fighting sleep) in any of the following situations?

### **Please check only those boxes that apply:**

- |   | Sleep Attack | Fight Sleep |
|---|--------------|-------------|
| • Eating food (meals)                         | ( )          | ( )         |
| • While talking with someone                  | ( )          | ( )         |
| • While at a meeting                          | ( )          | ( )         |
| • As a passenger in a car (or train or plane) | ( )          | ( )         |
| • Watching television                         | ( )          | ( )         |
| • Listening to the radio or stereo            | ( )          | ( )         |
| • Reading a book                              | ( )          | ( )         |

**Please complete the following situations that apply:**

How many times have you EVER had ACCIDENTS or been reprimanded at WORK or SCHOOL because of sleepiness: \_\_\_\_\_times

How many times have you EVER been involved in AUTOMOBILE ACCIDENTS, or NEAR ACCIDENTS because of sleepiness or fatigue: \_\_\_\_\_times

HOW many PLANNED naps do you usually take during a usual WEEKDAY or WEEKEND: \_\_\_\_\_naps

How many times do you DOZE OFF UNINTENTIONALLY on a usual WEEKDAY or WEEKEND: \_\_\_\_\_times

***Health***

What is (or was) your body weight?

Now: \_\_\_\_\_lbs.

6 months ago: \_\_\_\_\_lbs

2 years ago: \_\_\_\_\_lbs

Height: \_\_\_\_\_ft. \_\_\_\_\_in.

How many times per week do you exercise? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

How many caffeinated beverages do you drink per day? \_\_\_\_\_ Per week? \_\_\_\_\_

On average, how many alcoholic beverages do you drink on weekdays? \_\_\_\_\_on weekends? \_\_\_\_\_

On average, how much tobacco do you smoke? \_\_\_\_\_cigarettes per day

**List ALL illnesses for which you are under treatment or have been treated for in the past:**

Name of illness: \_\_\_\_\_ Year of onset \_\_\_\_\_

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Name of illness: \_\_\_\_\_ Year of onset \_\_\_\_\_

Name of illness: \_\_\_\_\_ Year of onset \_\_\_\_\_

**List ALL hospital admissions (including surgical operations and psychiatric admissions), beginning with the most recent:**

\_\_\_\_\_ month/year  
\_\_\_\_\_

_____	_____
_____	_____
_____	_____

**List ALL current medications (prescription and over-the counter):**

_____	dosage/day
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used any medication (prescription or over the counter) to help you sleep?	YES	NO
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Have you ever had any adverse reactions to a medicine(s) If yes, which one(s): _____	YES	NO
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Do you have any drug allergies? If yes, which one(s): _____	YES	NO
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***Mental Health***

Are you currently receiving psychological or psychiatric treatment for emotional or mental health problems?	YES	NO
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Have you ever been treated for emotional or mental health problems in the past?	YES	NO
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Are you currently or have you ever taken medication for depression, anxiety or any other emotional problem?	YES	NO
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Have you ever been treated for alcohol/substance abuse problems?	YES	NO
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In the last month, has there been a period of time when you were feeling depressed or down most of the day nearly every day?	YES	NO
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In the past 6 months, have you been more nervous or anxious than usual? YES NO

During the night you cannot seem to stop thinking or worrying? YES NO

***Family History***

**Has anyone in your family had (check those that apply):**

	Mother	Father	Sibling
• Insomnia	_____	_____	_____
• Sleepiness during the day	_____	_____	_____
• Sleep Apnea	_____	_____	_____
• Emotional or psychiatric problems	_____	_____	_____
• Hospitalized for psychiatric problems	_____	_____	_____
• Diabetes	_____	_____	_____
• Obesity	_____	_____	_____
• Allergies or asthma	_____	_____	_____
• High blood pressure	_____	_____	_____
• Heart disease	_____	_____	_____
• Stroke	_____	_____	_____
• Thyroid Problems	_____	_____	_____
• Cancer	_____	_____	_____

***Additional Information***

Is there anything else not covered by this questionnaire regarding your sleeping or waking issues that you would like to tell us about?

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***Please review the questionnaire to see if you have answered ALL questions. This will help us to better understand your sleep concerns. Thank You.***