

**Advocate Lutheran General Hospital
Sleep Disorder Center
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Phone 847-723-7024 Fax 847-723-7369**

**Advocate Medical Group
Sleep Disorder Center
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Arlington Heights, IL 60005
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Sleep Disorder Center Questionnaire for *Significant Other*

Patient's Name: _____

Spouse/Significant Other's Name: _____

Instructions

This questionnaire should be filled out by the patient's Significant Other regarding the sleep habits of the patient who will be seen in the Sleep Disorder Center. It is important that the Significant Other answer each question as completely and as accurately as possible.

General

Why is your spouse/partner being referred to the Sleep Disorder Center?

**Please indicate how severe of a problem you feel your partner has with the following:
(Circle the number at right)**

	Never	—————>			Always
	1	2	3	4	5
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
With not feeling refreshed, no matter how much he/she sleeps?	1	2	3	4	5

Has he or she had any previous evaluations, examinations, or treatment for this sleep problem or any other problem with his/her sleep?

YES

NO

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

Sleep/Wake Schedule on Weekdays (Workdays)

What is his/her usual bedtime on weekdays (workdays)? _____ am/pm

What time does he/she get out of bed on weekdays (work days)? _____ am/pm

How long does it usually take him/her to fall asleep after deciding to go to bed? _____ minutes

On average, how many times does he/she awaken during the night? _____ times

On a typical night, how long does he/she 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 he/she usually gets on weekdays (work days)? _____ hours

Does he/she have the same sleep-awake schedule on weekends (non-work days)? YES NO

If no, describe: _____

Sleep Related Symptoms

The following questions pertain to symptoms your spouse or significant other may experience **JUST PRIOR TO FALLING ASLEEP, DURING SLEEP, and OR UPON AWAKENING.**

HOW OFTEN does he or she:

	Never	Monthly	Nightly		
• Experience crawling or aching leg feeling 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 he/she is asleep?	1	2	3	4	5
• Awaken screaming, violent, or 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 dream-like scenes even though he/she knows that he/she is 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 has he/she ever experienced sudden bodily weakness and/or fallen?

YES NO

During sleep

Does he or she:

	Never	Monthly	Nightly		
• Snore	1	2	3	4	5
• Hold his/her breath or breathing while asleep?	1	2	3	4	5
• Suddenly wake up gasping for breath or unable to breathe?	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
• Breath through his/her mouth?	1	2	3	4	5
• Experience pain or physical discomfort?	1	2	3	4	5
• Have chest pain?	1	2	3	4	5
• Have a persistent cough that disturbs his/her sleep?	1	2	3	4	5
• Complain of “gas” in his/her stomach, indigestion or experiences 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 his/her teeth while asleep?	1	2	3	4	5
• Experience restless, disturbed sleep?	1	2	3	4	5
• Disturb your sleep?	1	2	3	4	5
• Depend on an alarm clock to wake up?	1	2	3	4	5
• Is unusually difficult to wake up in the morning?	1	2	3	4	5

Daytime Functioning

During the past six months, has he or she EITHER fallen asleep without intending to (sleep attacks), or struggled to stay awake (fighting sleep) in any of the following situations:

Please check only those boxes that apply:

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

Please complete the following items below that apply:

Has your spouse/partner had ACCIDENTS or been reprimanded at WORK OR SCHOOL because of sleepiness? _____ times

Has your spouse/partner been involved in AUTOMOBILE ACCIDENTS, or NEAR ACCIDENTS, because of sleepiness or fatigue? _____ times

How many PLANNED naps does he or she usually take during a usual WEEKDAY OR WEEKEND? _____ times

How many times does he or she DOZE OFF UNINTENTIONALLY on a usual WEEKDAY OR WEEKEND? _____ times

Health

What is his or her body weight?

Now: _____ lbs

6 months ago: _____ lbs

2 years ago: _____ lbs

How many times per week does he/she exercise? _____

What type of exercise does he/she do? _____

How many caffeinated beverages does he/she drink on weekdays? _____

On average, how many alcoholic beverages does he/she drink on weekdays? _____

On average, how many alcoholic beverages does he/she drink on weekends? _____

On average, how much tobacco does he/she smoke? _____ cigarettes per day

Additional Information

Is there anything else not covered by this questionnaire regarding your spouse/partner's sleeping or waking problem that you would like to tell us about?

Please check through the questionnaire to ensure that you have answered all the questions. This will help us to better understand your spouse/partner's sleeping issues. Thank You.