

Hopkins Sleep Survey (continued)

Caffeine (Use the information given below to estimate the number of ounces)

Small cup = 5 oz Regular or small mugcup = 8 oz Large mug = 12 oz
 Regular can of soda/cola = 12 oz Regular bottle of water = 20 oz

On a **typical day**, how many **ounces of caffeinated coffee, tea, cola/sodas** do you drink?
 (Please choose one response per beverage - DO NOT include decaffeinated beverages)

Coffee	Tea	Colas/Sodas
<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> None
<input type="radio"/> Less than 8 oz	<input type="radio"/> Less than 8 oz	<input type="radio"/> Less than 8 oz
<input type="radio"/> 8-16 oz	<input type="radio"/> 8-16 oz	<input type="radio"/> 8-16 oz
<input type="radio"/> 16-24 oz	<input type="radio"/> 16-24 oz	<input type="radio"/> 16-24 oz
<input type="radio"/> 24-48 oz	<input type="radio"/> 24-48 oz	<input type="radio"/> 24-48 oz
<input type="radio"/> 48-72 oz	<input type="radio"/> 48-72 oz	<input type="radio"/> 48-72 oz
<input type="radio"/> More than 72 oz	<input type="radio"/> More than 72 oz	<input type="radio"/> More than 72 oz

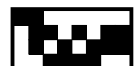
How often do you use caffeine containing pills (e.g. No Doz)?

- Never Less than monthly 2-4 times/month 2-4 times/week Daily

The following questions are related to your sleep during the past few months.
 Please carefully read each question and give the SINGLE best answer.

	Less than 3	4 to 6	7	8	9	10 to 12	More than 12
How many hours do you try to sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How long do you actually sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How satisfied are you with your:	<u>Very Satisfied</u>			<u>Very Dissatisfied</u>			
Current sleep quality?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
Current daytime alertness?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
Ability to feel rested after your night's sleep?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

PLEASE TURN THE PAGE AND CONTINUE THE SURVEY



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How often do you (or your bed partner/roommate) find that you:

		Never	Rarely	Sometimes	Often	Usually	Always
1. Snore so loudly that it would bother others near you	1.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Sleep apart from your bed partner or roommate because of snoring	2.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Have trouble breathing at night	3.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Awaken choking or gasping	4.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Have others say that you stop breathing in your sleep	5.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Are bothered by physical problems and sensations at night	6.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Have palpitations or chest pain at night	7.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Take one or more naps during the day	8.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Feel refreshed after a nap	9.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Struggle to stay awake several times during the day	10.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Are tired and fatigued even when you are not drowsy	11.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Doze or nod off while watching a movie or TV show, a lecture or reading	12.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Doze or nod off while at work	13.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Doze or nod off while driving	14.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Doze or nod off while on the phone or in embarrassing situations	15.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Feel sleepy and drowsy all day (morning and afternoon)	16.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Are tired or sleepy in the morning	17.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Wake up tired or NOT rested	18.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Have trouble keeping alert during the afternoon	19.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Are tired or sleepy in the early evening	20.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Have trouble staying awake until bed time	21.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Are more awake and alert in the evening than morning	22.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Wake up and are alert in the morning before it is time to get up	23.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Sleep longer on weekends or holidays than on weekdays	24.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Have trouble getting to sleep	25.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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How often do you (or your bed partner/roommate) find that you:

	Never	Rarely	Sometimes	Often	Usually	Always
26. Have trouble staying asleep after you have fallen asleep	26.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Awaken early in the morning and have trouble getting back to sleep	27.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Lie awake at night with thoughts racing through your mind	28.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Lie awake at night worried or depressed	29.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Are awakened easily by noise, light or other things	30.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Are too full of energy or have many exciting/important things to do to sleep	31.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Have strong, strange, disturbing feelings in your arms and legs when awake which go away or are less disturbing if you move your legs	32.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Have times you feel you must repeatedly move your legs (can't be still)	33.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Have twitches, jerks or startled movements during sleep	34.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Have restless sleep or awaken with bedclothes or sheets in a mess	35.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. Move about so much in your sleep that a bed partner would likely complain	36.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. Sit up and scream while asleep or suddenly wake up scared	37.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. Walk while asleep, with no recall of this the next day	38.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. Walk during dreaming or act out the dream	39.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. Have frightening dreams or nightmares	40.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. Have vivid dreams shortly after falling asleep	41.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. Have dreams during naps	42.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. Heard a voice or saw things like a vision while falling asleep or awakening	43.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. Felt paralyzed, totally unable to move, but mentally alert while falling asleep or awakening	44.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. Have sudden physical weakness of arms, legs or face when laughing, crying, or during other emotional situations	45.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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How often do you (or your bed partner/roommate) find that you:

	Never	Rarely	Sometimes	Often	Usually	Always
46. Are refreshed and awake even after short (10-15 min) naps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. Use alcohol to help you sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. Use sleeping pills to help you sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
49. Use medicine to help you stay awake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. Use coffee, tea, cola or other stimulants to help you stay awake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

HISTORY

MEDICAL HISTORY: Please choose ALL that apply. (Y: Yes N: No U: Unknown)

A) Heart Disease:

- | | | |
|--|---|---|
| <input type="radio"/> <input type="radio"/> <input type="radio"/> High Blood Pressure | <input type="radio"/> <input type="radio"/> <input type="radio"/> Coronary Artery Disease | <input type="radio"/> <input type="radio"/> <input type="radio"/> Heart Attack |
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Irregular heart rhythm | <input type="radio"/> <input type="radio"/> <input type="radio"/> Angina | <input type="radio"/> <input type="radio"/> <input type="radio"/> Heart failure |
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Bypass surgery | <input type="radio"/> <input type="radio"/> <input type="radio"/> Heart Murmur | |

B) Lung Disease:

- | | | |
|---|--|---|
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Asthma | <input type="radio"/> <input type="radio"/> <input type="radio"/> Chronic bronchitis | <input type="radio"/> <input type="radio"/> <input type="radio"/> Emphysema |
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Pneumonia | <input type="radio"/> <input type="radio"/> <input type="radio"/> Clots in leg or lung | |

C) Sinus Disease:

- | | | |
|---|--|---|
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Hay Fever | <input type="radio"/> <input type="radio"/> <input type="radio"/> Chronic/frequent sinusitis | <input type="radio"/> <input type="radio"/> <input type="radio"/> Deviated septum |
|---|--|---|

D) Gastrointestinal Disease:

- | | | |
|---|---|--|
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Ulcers | <input type="radio"/> <input type="radio"/> <input type="radio"/> Hiatal Hernia | <input type="radio"/> <input type="radio"/> <input type="radio"/> Gall bladder disease |
| <input type="radio"/> <input type="radio"/> <input type="radio"/> Acid reflux | <input type="radio"/> <input type="radio"/> <input type="radio"/> Hepatitis | <input type="radio"/> <input type="radio"/> <input type="radio"/> Pancreatitis |



Hopkins Sleep Survey (continued)

E) Endocrine Disease:

Y N U Diabetes

Y N U Thyroid Disease

Y N U High Cholesterol

F) Kidney and Urinary Disease:

Y N U Kidney Stones

Y N U Kidney Failure

Y N U Dialysis

Y N U Prostate Problems

Y N U Bladder Problems

Y N U Urinary tract infections

G) Joint Disease:

Y N U Osteoarthritis

Y N U Rheumatoid Arthritis

Affected Joints:

Y N U Spine

Y N U Shoulders

Y N U Hips

Y N U Knees

Y N U Hands

H) Neurologic Disease:

Y N U Stroke

Y N U Paralysis

Y N U Headaches

Y N U Vision/Hearing Loss

Y N U Seizures/Epilepsy

Y N U Parkinson's Disease

I) Psychiatric Disease:

Y N U Depression

Y N U Bipolar Disorder

Y N U History of psychiatric treatment

Y N U Anxiety Disorder

J) Other Disease/Problem:

Y N U Cancer

Y N U Anemia

Y N U Gynecological problems

Y N U Trauma

Y N U Chronic/Intermittent Back Pain

Y N U Impotence

SURGICAL HISTORY:

		<u>YEAR</u>			<u>YEAR</u>
Tonsillectomy (Tonsils)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____	Appendectomy (Appendix)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____
Hysterectomy (Uterus)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____	Cholecystectomy (Gall Bladder)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____
Throat Surgery for Snoring	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____	Sinus Surgery	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	_____
Other surgeries that you have had		_____			_____



Hopkins Sleep Survey (continued)

ALLERGIES (Please list **ALL DRUGS** that you are allergic to and the allergic reaction):

MEDICATIONS (List **ALL** medications YOU are taking)

NAME	DOSE (mg)	TIMES/DAY

Do you ever use sleeping pills, tranquilizers or sedatives?

NAME	DOSE (mg)	TIMES/DAY

FAMILY HISTORY:

Does any family member (father, mother, brother or sister) have a sleep disorder?

- If yes,** what type of sleep disorder
- Sleep Apnea found during a sleep study
 - Narcolepsy
 - Restless Legs Syndrome
 - Heavy Snoring
 - Sleep Walking

Family member who has the problem:

	<u>Alive</u>	<u>Age Now</u> (or at death)	<u>Medical Problems</u>
Father:	<input type="radio"/> <input type="radio"/>	_____	_____
Mother:	<input type="radio"/> <input type="radio"/>	_____	_____
Brothers:	<input type="radio"/> <input type="radio"/>	_____	_____
	<input type="radio"/> <input type="radio"/>	_____	_____
	<input type="radio"/> <input type="radio"/>	_____	_____



Hopkins Sleep Survey (continued)

	<u>Alive</u>	<u>Age Now</u> (or at death)	<u>Medical Problems</u>
Sisters:	(Y) (N)	_____	_____
	(Y) (N)	_____	_____
	(Y) (N)	_____	_____

	<u>Sex</u>	<u>Age</u>	<u>Alive</u>	<u>Medical Problems</u>
Children:	(M) (F)	_____	(Y) (N)	_____
	(M) (F)	_____	(Y) (N)	_____
	(M) (F)	_____	(Y) (N)	_____
	(M) (F)	_____	(Y) (N)	_____
	(M) (F)	_____	(Y) (N)	_____

How **likely** are you to **doze off or fall asleep** in the following situations? Even if you have not done some of these things recently, try to answer how these activities may affect you. Use the following scale to choose the most appropriate response for each situation: (Choose only one response for each question)

- A) Sitting and reading**
- B) Watching television**
- C) Sitting, inactive in a public place (e.g. a theatre or a meeting)**
- D) As a passenger in a car for an hour without a break**
- E) Lying down to rest in the afternoon when circumstances permit**
- F) Sitting and talking to someone**
- G) Sitting quietly after a lunch without alcohol**
- H) In a car, while stopped for a few minutes in traffic**

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
A)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please describe your personality traits as you see them:

