

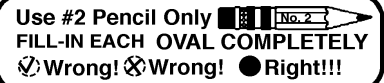


The Hopkins Sleep Survey

Please give careful attention to completing this health survey. The first two pages are questions regarding your medical history. The next two pages are questions related to your sleep. Consult your spouse, bed-partner, roommate, or family members for help in answering any of the questions.

Marking Instructions:

Make heavy black marks that darken the circle completely.
If you change your mind, please erase completely.
Unless the instructions tell you otherwise, darken only **ONE** circle.



Your Name: _____

Sex: Male Female

What is your primary sleep problem? (Please be brief)

Social Security No.	Date Completed			Birth Date		
Last 4 Digits	Mo.	Day	Year	Mo.	Day	Year
0 0 0 0	0	0	0	0	0	0
1 1 1 1	1	1	1	1	1	1
2 2 2 2	2	2	2	2	2	2
3 3 3 3	3	3	3	3	3	3
4 4 4 4	4	4	4	4	4	4
5 5 5 5	5	5	5	5	5	5
6 6 6 6	6	6	6	6	6	6
7 7 7 7	7	7	7	7	7	7
8 8 8 8	8	8	8	8	8	8
9 9 9 9	9	9	9	9	9	9

- Marital Status:**
- Single
 - Married
 - Separated
 - Divorced
 - Widowed

Do you currently have a bed partner/roommate?
 Yes No

If yes, did your bed partner/roommate assist with this survey? Yes No

- Race:**
- African American
 - American Indian / Native American
 - Asian or Pacific Islander
 - Caucasian / White
 - Hispanic
 - Multiracial

Have you been to a sleep specialist before?
 Yes No

Have you ever had a sleep study before?
 Yes No

- Who INITIALLY suspected a sleep problem?**
- You feel that you have a sleep problem
 - Your spouse, bed-partner, or roommate
 - Your physician suspects a sleep disorder

- What is the **highest grade** you finished in school?
- Grades 1 – 8
 - Grades 9 – 11
 - High School Graduate / GED equivalent
 - Junior College / Vocational Degree
 - Some College (Less than 4 years)
 - College Degree
 - Advanced Degree (Masters, PhD, MD, JD)

- If your physician** suspects a sleep disorder, what is his/her **specialty**? (Choose one)
- Family Practice / Internal Medicine
 - Pulmonary Medicine (Lung Specialist)
 - Ear, Nose and Throat Specialist
 - Neurologist
 - Psychiatrist
 - Other

- Because** of your sleep problems, have you:
- Considered (or are on) disability? Yes No
 - Had work (or school) difficulties? Yes No
 - Had motor vehicle accidents? Yes No
 - Had driving problems? Yes No

Employment History (Please choose only one response)

Homemaker On disability Unemployed Retired Part Time Full Time

Do you **regularly** work rotating shifts? Yes No

Do you **regularly** work night shift? Yes No

Tobacco (Report cigarette use only)

1. Have you **EVER** smoked cigarettes (More than 5 packs in a lifetime)? Yes No

2. Do you smoke cigarettes **NOW** (As of 1 month ago)? Yes No

3. **If you smoke now**, how many packs of cigarettes do you smoke per day?
 ½ or less 1 1½ 2 2½ 3 3½ 4 or more

4. **If you stopped smoking completely**, how many packs of cigarettes did you smoke per day?
 ½ or less 1 1½ 2 2½ 3 3½ 4 or more

5. How many **years** have you smoked? (Include past & present)
 1 - 5 6 - 10 11 - 15 16 - 20 21 - 25 26 - 30 31 - 35 36 or more

Alcohol (Beer, Wine and Liquor)

1. How often do you have a **drink containing alcohol**?
 Never Less than monthly 2-4 times/month 2-4 times/week Daily

2. How many drinks **containing alcohol** do you have on a typical day when you are drinking?
 1 to 2 3 to 4 5 to 6 7 to 8 9 or more

3. If and when you do drink, how often do you have **six or more drinks** containing alcohol?
 Never Less than monthly 2-4 times/month 2-3 times/week Daily

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

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

Caffeinated beverage:	None	Less than 8oz	8-16 oz	16-24 oz	24-48 oz	48-72 oz	More than 72 oz
a) Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Colas or Sodas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you use any caffeine containing pills (e.g., No Doz) regularly? Yes No

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

How many hours do you try to sleep : Less than 3 4 to 6 7 8 9 10 to 12 More than 12
How long do you actually sleep ?

How satisfied are you with your:

	Very Satisfied					Very Dissatisfied	
Current sleep quality?	①	②	③	④	⑤	⑥	⑦
Current daytime alertness?	①	②	③	④	⑤	⑥	⑦
Ability to feel rested after a night's sleep?	①	②	③	④	⑤	⑥	⑦



The Hopkins Sleep Survey

Use #2 Pencil Only No. 2
FILL-IN EACH OVAL COMPLETELY
✔ Wrong! ✘ Wrong! ● Right!!!

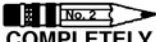
Never: Not experienced the problem in the past year
Rarely: Experience the problem less than once per month
Sometimes: Experience the problem few times a month
Often: Experience the problem during most weeks of the month
Usually: Experience the problem 2 to 5 times a week
Always: Experience the problem on most days of the week

Never Rarely Sometimes Often Usually Always
▼ ▼ ▼ ▼ ▼ ▼

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

- 1. Snore so loudly that it would bother others near you
- 2. Sleep apart from your bed partner or roommate because of snoring
- 3. Have trouble breathing at night
- 4. Awaken choking or gasping
- 5. Have others say that you stop breathing in your sleep
- 6. Are bothered by physical problems, pain or sensations at night
- 7. Have palpitations or chest pain at night
- 8. Take one or more naps during the day
- 9. Feel refreshed after a nap
- 10. Struggle to stay awake several times during the day
- 11. Are tired and fatigued even when you are not drowsy
- 12. Doze or nod off while watching a movie or TV show, a lecture or reading
- 13. Doze or nod off while at work
- 14. Doze or nod off while driving
- 15. Doze or nod off while on the phone or in embarrassing situations
- 16. Feel sleepy and drowsy all day (morning and afternoon)
- 17. Are tired or sleepy in the morning
- 18. Wake up tired or NOT rested
- 19. Have trouble keeping alert during the afternoon
- 20. Are tired or sleepy in the early evening
- 21. Have trouble staying awake until bed time
- 22. Are more awake and alert in the evening than morning
- 23. Wake up and are alert in the morning before it is time to get up
- 24. Sleep longer on weekends or holidays than on weekdays
- 25. Have trouble getting to sleep

Never: Not experienced the problem in the past year
Rarely: Experience the problem less than once per month
Sometimes: Experience the problem few times a month
Often: Experience the problem during most weeks of the month
Usually: Experience the problem 2 to 5 times a week
Always: Experience the problem on most days of the week

Use #2 Pencil Only  No. 2
 FILL-IN EACH OVAL COMPLETELY
 ☑ Wrong! ☒ Wrong! ● Right!!!

Never Rarely Sometimes Often Usually Always
 ▼ ▼ ▼ ▼ ▼ ▼

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

- | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 26. Have trouble staying asleep after you have fallen asleep | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Lie awake at night worried or depressed | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 32. Have strong, strange, disturbing feelings in your arms or legs when awake which go away or are less disturbing if you move your legs | <input type="radio"/> | <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) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. Have twitches, jerks or startled movements during sleep | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 39. Walk during dreaming or act out the dream | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 40. Have frightening dreams or nightmares | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 41. Have vivid dreams shortly after falling asleep | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 42. Have dreams during naps | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 46. Are refreshed and awake even after short (10-15 min) nap | <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 or medicine 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"/> |

FAMILY HISTORY: Does any member have a sleep disorder ?

Yes No

If Yes, what type of sleep disorder?

Family member(s) who have the problem:

- Sleep Apnea found during a sleep study
- Narcolepsy
- Restless Legs Syndrome
- Heavy Snoring
- Sleep Walking

	<u>Living?</u>	<u>Age Now</u> (or at death)	<u>Medical problems</u>
Father:	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
Mother:	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
Brother(s)	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
Sister(s):	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
	<input type="radio"/> Yes <input type="radio"/> No	_____	_____

Children:	<u>Sex</u>	<u>Age</u>	<u>Living ?</u>	<u>Medical Problems</u>
	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	_____
⑩	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	_____

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 on how these activities may affect you. Use the following scale to choose the most appropriate number for each situation (Choose only one response per question):

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
A. Sitting and reading	①	②	③	④
B. Watching television	①	②	③	④
C. Sitting, inactive in a public place (e.g. a theater or a meeting)	①	②	③	④
D. As a passenger in a car for an hour without a break	①	②	③	④
E. Lying down to rest in the afternoon when circumstances permit	①	②	③	④
F. Sitting and talking to someone	①	②	③	④
G. Sitting quietly after a lunch without alcohol	①	②	③	④
H. In a car, while stopped for a few minutes in the traffic	①	②	③	④

Please describe your personality traits as you view them:

Thank you filling out the survey. Please bring the **entire** questionnaire packet with you during your clinic visit.