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	0 0	0 0	0 0
1 1 1 1	1 1	1 1	1 1	1 1	1 1	1 1
2 2 2 2	2	2 2	2 2	2	2 2	2 2
3 3 3 3	3	3 3	3 3	3	3 3	3 3
4 4 4 4	4	4	4 4	4	4	4 4
5 5 5 5	5	5 5	5 5	5	5 5	5 5
6 6 6 6	6	6 6	6 6	6	6 6	6 6
7 7 7 7	7	7 7	7 7	7	7 7	7 7
8 8 8 8	8	8 8	8 8	8	8 8	8 8
9 9 9 9	9	9 9	9 9	9	9 9	9 9

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

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

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

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

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

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

Have you been to a sleep specialist before?
○ Yes ○ No

Have you ever had a sleep study before?
○ Yes ○ No

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)

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	○	○	○	○	○	○	○
b) Tea	○	○	○	○	○	○	○
c) Colas or Sodas	○	○	○	○	○	○	○

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.

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

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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
FILL-IN EACH OVAL COMPLETELY
Wrong! Wrong! Right!!!

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	○	○	○	○	○	○
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	○	○	○	○	○	○

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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

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	○	○	○	○	○	○
27. Awaken early in the morning and have trouble getting back to sleep	○	○	○	○	○	○
28. Lie awake at night with thoughts racing through your mind	○	○	○	○	○	○
29. Lie awake at night worried or depressed	○	○	○	○	○	○
30. Are awakened easily by noise, light, or other things	○	○	○	○	○	○
31. Are too full of energy or have many exciting/important things to do to sleep	○	○	○	○	○	○
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	○	○	○	○	○	○
33. Have times you feel you must repeatedly move your legs (can't be still)	○	○	○	○	○	○
34. Have twitches, jerks or startled movements during sleep	○	○	○	○	○	○
35. Have restless sleep or awaken with bedclothes or sheets in a mess	○	○	○	○	○	○
36. Move about so much in your sleep that a bed partner would likely complain	○	○	○	○	○	○
37. Sit up and scream while asleep or suddenly wake up scared	○	○	○	○	○	○
38. Walk while asleep, with no recall of this the next day	○	○	○	○	○	○
39. Walk during dreaming or act out the dream	○	○	○	○	○	○
40. Have frightening dreams or nightmares	○	○	○	○	○	○
41. Have vivid dreams shortly after falling asleep	○	○	○	○	○	○
42. Have dreams during naps	○	○	○	○	○	○
43. Heard a voice or saw things like a vision while falling asleep or awakening	○	○	○	○	○	○
44. Felt paralyzed, totally unable to move, but mentally alert while falling asleep or awakening	○	○	○	○	○	○
45. Have sudden physical weakness of arms, legs or face when laughing, crying or during other emotional situations	○	○	○	○	○	○
46. Are refreshed and awake even after short (10-15 min) nap	○	○	○	○	○	○
47. Use alcohol to help you sleep	○	○	○	○	○	○
48. Use sleeping pills or medicine to help you sleep	○	○	○	○	○	○
49. Use medicine to help you stay awake	○	○	○	○	○	○
50. Use coffee, tea, cola or other stimulants to help you stay awake	○	○	○	○	○	○

MEDICAL HISTORY (Choose **all** that apply to you):

A) Heart Disease:
- ○ High blood pressure
- ○ Coronary artery disease
- ○ Heart Attack
- ○ Irregular heart rhythm
- ○ Angina
- ○ Heart failure
- ○ Bypass surgery
- ○ Heart murmur

B) Lung Disease
- ○ Asthma
- ○ Chronic bronchitis
- ○ Emphysema
- ○ Frequent pneumonia
- ○ Clots in leg or lung

C) Sinus Disease
- ○ Hay fever
- ○ Chronic / frequent sinusitis
- ○ Deviated septum

D) Gastrointestinal Disease
- ○ Ulcers
- ○ Hiatal Hernia
- ○ Gallbladder Disease
- ○ Acid Reflux
- ○ Hepatitis
- ○ Pancreatitis

E) Endocrine Disease
- ○ Diabetes
- ○ Thyroid Disease
- ○ High Cholesterol

F) Kidney and Urinary Tract Disease
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Dialysis
- ○ Prostate Problems
- ○ Bladder Problems
- ○ Urinary tract infections

G) Joint Disease
- ○ Osteoarthritis
- ○ Rheumatoid arthritis

Affected joints:
○ Spine ○ Shoulders ○ Hips ○ Knees ○ Hands

H) Neurologic Disease
- ○ Stroke
- ○ Paralysis
- ○ Headaches
- ○ Vision/Hearing Loss
- ○ Seizures/Epilepsy
- ○ Parkinson's Disease

I) Psychiatric Disease
- ○ Depression
- ○ Bipolar Disorder
- ○ History of psychiatric treatment
- ○ Anxiety Disorder

J) Other Disease/Problems
- ○ Cancer
- ○ Anemia
- ○ Gynecological problems
- ○ Trauma
- ○ Chronic/Intermittent Back Pain
- ○ Impotence
- ○ Chronic Pain (Not Back)
- ○ Loss of Libido

SURGICAL HISTORY (Choose all that apply to you):

	YES	NO	Year
Tonsillectomy (Tonsils)	○	○	_____
Appendectomy (Appendix)	○	○	_____
Hysterectomy (Uterus)	○	○	_____
Cholecystectomy (Gall Bladder)	○	○	_____
Throat Surgery for Snoring	○	○	_____
Sinus Surgery	○	○	_____

Other surgeries that you have had:

_____ _____

_____ _____

ALLERGIES (List **ALL DRUGS** that you are allergic to)

_____

_____

Do you have any allergies to:

Foods? ○ Yes ○ No

Dusts/Pollens? ○ Yes ○ No

MEDICATIONS (List **ALL** medications you are taking)**:**

NAME DOSE (mg) TIMES/DAY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you ever use sleeping pills, tranquilizers or sedatives?

○ Yes ○ No If yes, please list :

NAME DOSE (mg) TIMES/DAY

_____

_____

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 _____

	Living?	**Age Now** (or at death)	**Medical problems**
Father:	○ Yes ○ No	_____	_____
Mother:	○ Yes ○ No	_____	_____
Brother(s)	○ Yes ○ No	_____	_____
	○ Yes ○ No	_____	_____
	○ Yes ○ No	_____	_____
Sister(s):	○ Yes ○ No	_____	_____
	○ Yes ○ No	_____	_____
	○ Yes ○ No	_____	_____

Children:	**Sex**	**Age**	**Living ?**	**Medical Problems**
	○ M ○ F	_____	○ Yes ○ No	_____
	○ M ○ F	_____	○ Yes ○ No	_____
	○ M ○ F	_____	○ Yes ○ No	_____
⓪	○ M ○ F	_____	○ Yes ○ 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. Siting and reading	⓪	①	②	③
B. Watching television	⓪	①	②	③
C. Sitting, inactive in a public place (e.g. a theater or a meeting)	⓪	①	②	③
D. As a passenger in a car for an hour without a break	⓪	①	②	③
E. Lying down to rest in the afternoon when circumstances permit	⓪	①	②	③
F. Sitting and talking to someone	⓪	①	②	③
G. Sitting quietly after a lunch without alcohol	⓪	①	②	③
H. In a car, while stopped for a few minutes in the traffic	⓪	①	②	③

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.