JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

Patient ID will go here.

Welcome!

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.

Your Name _____ Sex: ☐ Male ☐ Female

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

Last Four Digits of Social Security Number ☐☐☐☐ Date Completed ☐☐-☐☐-☐☐☐☐ Birth Date ☐☐-☐☐-☐☐☐☐

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race ☐ African-American ☐ Hispanic ☐ American Indian/Native American ☐ Caucasian/White ☐ Asian or Pacific Islander ☐ Other _____

Who INITIALLY suspected a sleep problem?

☐ You suspect 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 practice **specialty** (Choose one)

☐ Family Practice/Internal Medicine ☐ Neurologist
☐ Pulmonary Medicine (Lung Specialist) ☐ Psychiatrist
☐ Ear, Nose and Throat Specialist
☐ Other_____

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

If yes, did your bed-partner/roommate assist with this questionnaire? ☐ 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/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 you 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 ☐ Full-Time ☐ Part-Time

Do you regularly work **rotating shifts**? ☐ Yes ☐ No
Do you regularly work **night shift**? ☐ Yes ☐ No

TOBACCO Report cigarette use only.

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

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

If you smoke now, how many packs of cigarettes do you smoke per day?

☐ ½ or less ☐ 1 ☐ 1½ ☐ 2 ☐ 2½ ☐ 3 ☐ 3½ ☐ 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+

How many years have you smoked? (Include past and present)

☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36+

ALCOHOL Beer, Wine and Liquor

How often do you have **a drink containing alcohol?**

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

How many drinks **containing alcohol** do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9+

How often do you have **six or more drinks** containing alcohol?

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

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Tear here and take this bottom part home with you so you can remember important things.

THINGS TO REMEMBER TO ASK MY DOCTOR

1. What is my main problem? _____
2. What do I need to do? _____
3. Why is it important for me to do this?_____
4. When will I start to feel better?_____
5. Other notes_____

CAFFEINE Use the information given below to estimate the number of ounces.

Small cup = 5 oz Regular or small mug/cup = 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? (Choose one response per beverage. DO NOT include decaffeinated beverages)

Coffee		**Tea**		**Colas/Sodas**	
☐ None	☐ 16-24 oz	☐ None	☐ 16-24 oz	☐ None	☐ 16-24 oz
☐ Less than 8 oz	☐ 24-48 oz	☐ Less than 8 oz	☐ 24-48 oz	☐ Less than 8 oz	☐ 24-48 oz
☐ 8-16 oz	☐ 48-72 oz	☐ 8-16 oz	☐ 48-72 oz	☐ 8-16 oz	☐ 48-72 oz
	☐ More than 72 oz		☐ More than 72 oz		☐ 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

RECENT SLEEP ACTIVITY

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

	< 3	4 to 6	7	8	9	10 to 12	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 your night's sleep?	1	2	3	4	5	6	7

SLEEP HABITS

Never: Not experienced the problem in the last year
Rarely: Experience the problem less than once per month
Sometimes: Experience the problem a few times per month
Often: Experience the problem during most weeks of the month
Usually: Experience the problem 2 to 5 times per 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**
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 said that you stop breathing in your sleep	☐	☐	☐	☐	☐	☐
6. Are bothered by physical problems and 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)	☐	☐	☐	☐	☐	☐

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.

How often do you (or your bed-partner/roommate) find that you:	Never	Rarely	Sometimes	Often	Usually	Always
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 bedtime	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐
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 too many exciting/important things to do to sleep	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐
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) naps	☐	☐	☐	☐	☐	☐
47. Use alcohol to help you sleep	☐	☐	☐	☐	☐	☐
48. Use sleeping pills 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	☐	☐	☐	☐	☐	☐

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Hand Washing is Important to Stop the Spread of Illness and Infection

Wash Your Hands After:

- **(and before!) Handling food or eating.**
- **Using the bathroom or changing diapers.**
- **Sneezing, coughing or blowing your nose.**
- **Touching a cut, open sore or wound.**
- **Playing outside.**
- **Playing with pets or cleaning up after them.**

MEDICAL HISTORY Please choose ALL that apply.

	Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown	
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	☐	☐	☐	Pancreatitus
E. Endocrine Disease	☐	☐	☐	Diabetes	☐	☐	☐	Thyroid disease	☐	☐	☐	High cholesterol
F. Kidney and Urinary Disease	☐	☐	☐	Kidney stones	☐	☐	☐	Kidney failure	☐	☐	☐	Dialysis
	☐	☐	☐	Prostate problems	☐	☐	☐	Bladder problems	☐	☐	☐	Urinary tract infections
G. Joint Disease	☐	☐	☐	Osteoarthritis	Please check affected joints: ☐ Spine ☐ Knees ☐ Shoulders ☐ Hands ☐ Hips							
	☐	☐	☐	Rheumatoid arthritis	☐ Spine ☐ Knees ☐ Shoulders ☐ Hands ☐ Hips							
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	☐	☐	☐	Gynecological problems	☐	☐	☐	Impotence
	☐	☐	☐	Trauma	☐	☐	☐	Chronic/intermittent back pain	☐	☐	☐	Loss of libido
	☐	☐	☐	Anemia	☐	☐	☐	Chronic pain (not back)				

SURGICAL HISTORY Chose all that apply to you.

Surgery:	Yes	No	Unknown		Year	Yes	No	Unknown		Year
	☐	☐	☐	Tonsillectomy (Tonsils)	_____	☐	☐	☐	Appendectomy (Appendix)	_____
	☐	☐	☐	Hysterectomy (Uterus)	_____	☐	☐	☐	Cholecystectomy (Gallbladder)	_____
	☐	☐	☐	Throat surgery for snoring	_____	☐	☐	☐	Sinus surgery	_____
Others: Please list	☐	☐	☐	_____	_____	☐	☐	☐	_____	_____

ALLERGIES Please list ALL DRUGS that you are allergic to and the allergic reaction.

Drug	Reaction	Drug	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.

MEDICATIONS Please list ALL medications YOU are taking.

Name of Medication	Dose (mg)	Times/Day	Name of Medication	Dose (mg)	Times/Day

Do you ever use sleeping pills, tranquilizers or sedatives? ☐ Yes ☐ No

Name of Medication	Dose (mg)	Times/Day	Name of Medication	Dose (mg)	Times/Day

FAMILY HISTORY

Does any family member (father, mother, brother or sister) have a sleep disorder? ☐ Yes ☐ No ☐ Unknown

If yes, what type of sleep disorder?	Yes	No	Unknown	Family member who has the problem			
Sleep Apnea found during a sleep study	☐	☐	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Narcolepsy	☐	☐	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Restless Legs Syndrome	☐	☐	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heavy Snoring	☐	☐	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sleep Walking	☐	☐	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister

	Alive	Sex	Age Now (or at death)	Medical Problems
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			
Brothers	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
Sisters	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
Children	☐ Yes ☐ No	☐ M ☐ F		
	☐ Yes ☐ No	☐ M ☐ F		
	☐ Yes ☐ No	☐ M ☐ F		

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.)

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
A. Sitting and reading	☐	☐	☐	☐
B. Watching television	☐	☐	☐	☐
C. Sitting inactive in a public place (e.g., a theater 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	☐	☐	☐	☐

Please describe your personality traits as you see them: _____

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Thank you for filling out the survey.

Please bring the entire questionnaire packet with you during your clinic visit.

JOHNS HOPKINS
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THE JOHNS HOPKINS HOSPITAL

Patient ID will go here.

Welcome!

Your Name _____

The Johns Hopkins Sleep-Wake Diary

Instructions: This is a sleep log. Please start filling this log out the night you receive this packet and continue until the night before your visit.

Each morning do the following:

1) Write in today's date.
2) Write in the day of the week.
3) With a pencil, darken in the boxes for the hours that you are in bed.
4) If you take any naps during any part of the day, mark them the same way.

Example: *If you slept from 10:30 p.m. to 6:00 a.m.*

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	05 / 17 / 2010
Day														Monday
12:00 noon														
1:00 p.m.														
2:00 p.m.														
3:00 p.m.														
4:00 p.m.														
5:00 p.m.														
6:00 p.m.														
7:00 p.m.														
8:00 p.m.														
9:00 p.m.														
10:00 p.m.														
11:00 p.m.														
12:00 mid.														
1:00 a.m.														
2:00 a.m.														
3:00 a.m.														
4:00 a.m.														
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9:00 a.m.														
10:00 a.m.														
11:00 a.m.														

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