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Sleep Disorders Clinic

## Sleep Evaluation

Name:				Date:	
Age:	Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
My Chief Complaint is:					

### Please check the appropriate answer:

1. Do you snore?

*If "yes" please continue with question 2. If "no" or "I don't know" please skip to question 6.*

Yes  No  I don't know

2. Your snoring is:

Softer than talking  As loud as talking  Louder than talking

3. Your snoring occurs:

Every/almost every night  A few times a week  Once or less a week

4. Your snoring is:

Frequently interrupted by pauses or choking  Occasionally interrupted by pauses or choking

Not interrupted as far as I know

5. Do you snore in every body position?

Yes  No  don't know

6. Do you have, or have you ever had a bed partner:

*If "yes" please continue with question 7. If "no" please skip to question 10.*

Yes  No

7. Has your bed partner ever said that you have pauses in your breathing or periods of stopped breathing during your sleep?

Yes  No

8. Has your bed partner ever commented that you snore?

Yes, loud snoring  Yes, soft snoring  No

9. If you snore, is it loud enough to bother her/him?

Yes  No

10. Has anyone besides a bed partner ever commented on your snoring (roommate, neighbor, family, etc.)

Yes (loud)  Yes (soft)  No

11. Do you feel fatigued, exhausted, tired or not up to par?

3 or 4 times a day  Nearly every day  Once or twice a week  Once or twice a month

Never or hardly ever

12. Do you feel that in some way your sleep is not refreshing or restful?

3 or 4 times a day  Nearly every day  Once or twice a week  Once or twice a month

Never or hardly ever

13. Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?

- 3 or 4 times a day  Nearly every day  Once or twice a week  Once or twice a month  
 Never or hardly ever

14. Do you wake up during the night or in the morning with headaches?

- Yes  No

15. When falling asleep or waking up do you feel paralyzed?

- Yes  No

16. Do you dream or hallucinate as you fall asleep?

- Yes  No

17. Do you feel weakness in response to anger, laughter or surprise?

- Yes  No

18. Are you a shift worker?

- Yes  No

19. Do you have trouble initiating and/or maintaining sleep?

- 3 or 4 times a day  Nearly every day  Once or twice a week  Once or twice a month  
 Never or hardly ever

20. What do you feel is your ideal amount of sleep per day?

- 2-3 hrs  5  6  7  8  9+

21. Estimate the average number of hours of sleep you have per day

- 2-3 hrs  5  6  7  8  9+

Answer the following questions by checking a number from 1 to 5.

**1(always), 2 (usually), 3 (sometimes), 4(rarely) or 5 (Never).** If you strongly agree with the statement and/or it never happens to you.

22. When falling asleep, I feel paralyzed (unable to move)

- 1  2  3  4  5

23. I get too little sleep at night

- 1  2  3  4  5

24. I often have a poor night's sleep

- 1  2  3  4  5

25. I have trouble getting to sleep at night

- 1  2  3  4  5

26. I wake up often during the night

- 1  2  3  4  5

27. My bedtime varies a lot

- 1  2  3  4  5

28. At bedtime, thoughts race through my mind

1  2  3  4  5

29. At bedtime, I feel sad and depressed

1  2  3  4  5

30. At bedtime, I worry about things

1  2  3  4  5

31. At bedtime, I feel muscular tension

1  2  3  4  5

32. At bedtime, I'm afraid of not being able to go to sleep

1  2  3  4  5

33. When falling asleep, I have "restless legs" (a feeling of crawling, aching, or inability to keep legs still)

1  2  3  4  5

34. I have been told I kick my legs during sleep

1  2  3  4  5

35. After waking at night, I fear I will not be able to get back to sleep

1  2  3  4  5

36. My night sleep is restless and disturbed

1  2  3  4  5

37. I act out my dreams

1  2  3  4  5

38. I used to sleep walk as a child

1  2  3  4  5

39. I have a lot of nightmares

1  2  3  4  5

40. My typical bedtime is: \_\_\_\_\_

41. It usually takes me: \_\_\_\_\_

42. My wakeup time is \_\_\_\_\_

42. I am out of bed at \_\_\_\_\_

**Past Medical History**

Have you ever taken:

Insulin?

Yes No

Cardiac drugs?

Yes No

Cancer chemotherapy?

Yes No

Thyroid medications?

Yes No



## Beck's Depression Inventory

**This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire**

*Carefully Read each item below and check next to the answer that best describes how you have been feeling the past few days.*

#1.

- 0- I do not feel sad
- 1- I feel sad
- 2- I am sad all the time and can't snap out of it
- 3- I am so sad or unhappy that I can't stand it

#2.

- 0- I am not particularly discouraged about the future
- 1- I feel discouraged about the future
- 2- I feel I have nothing to look forward to
- 3- I feel that the future is hopeless and that things cannot improve

#3.

- 0- I do not feel like a failure
- 1- I feel I have failed more than the average person.
- 2- As I look back on my life, all I can see is a lot of failures
- 3- I feel I am a complete failure as a person

#4

- 0- I get as much satisfaction out of things as I used to
- 1- I don't enjoy things the way I used to
- 2- I don't get real satisfaction out of anything anymore
- 3- I am dissatisfied or bored with everything

#5

- 0- I don't feel particularly guilty
- 1- I feel guilty a good part of the time.
- 2- I feel quite guilty most of the time
- 3- I feel guilty all of the time

#6

- 0- I don't feel I am being punished
- 1- I feel I may be punished
- 2- I expect to be punished
- 3- I feel I am being punished

#7

- 0- I don't feel disappointed in myself
- 1- I am disappointed in myself
- 2- I am disgusted with myself
- 3- I hate myself

#8

- 0- I don't feel I am worse than anybody else
- 1- I am critical of myself for my weaknesses or mistakes
- 2- I blame myself all the time for my faults
- 3- I blame myself for everything bad that happens

#9

- 0- I don't have any thoughts of killing myself.
- 1- I have thoughts of killing myself, but I would not carry them out.
- 2- I would like to kill myself.
- 3- I would kill myself if I had the chance.

#10

- 0- I don't cry any more than usual.
- 1- I cry more now than I used to.
- 2- I cry all the time now.
- 3- I used to be able to cry, but now I can't even cry even though I want to.

#11

- 0- I am no more irritated by things than I ever am.
- 1- I am slightly more irritated now than usual.
- 2- I am quite annoyed or irritated a good deal of the time.
- 3- I feel irritated all the time now.

#12

- 0- I have not lost interest in other people.
- 1- I am less interested in other people than I used to be.
- 2- I have lost most of my interest in other people.
- 3- I have lost all of my interest in other people.

#13

- 0- I make decisions about as well as I ever could.
- 1- I put off making decisions more than I used to.
- 2- I have greater difficulty in making decisions than before.
- 3- I can't make decisions at all anymore.

#14

- 0- I don't feel that I look any worse than I used to.
- 1- I am worried that I am looking old or unattractive.
- 2- I feel that there are permanent changes in my appearance that make me look unattractive.
- 3- I believe that I look ugly.

#15

- 0- I can work about as well as before.
- 1- It takes an extra effort to get started at doing something.
- 2- I have to push myself very hard to do anything.
- 3- I can't do any work at all.

#16

- 0- I can sleep as well as usual.
- 1- I don't sleep as well as I used to.
- 2- I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
- 3- I wake up several hours earlier than I used to and cannot get back to sleep

#17

- 0- I don't get tired more than usual.
- 1- I get tired more easily than I used to.
- 2- I get tired from doing almost anything.
- 3- I am too tired to do anything.

#18

- 0- My appetite is no worse than usual.
- 1- My appetite is not as good as it used to be.
- 2- My appetite is much worse now.
- 3- I have no appetite at all anymore.

#19

- 0- I haven't lost much weight, if any, lately.
- 1- I have lost more than five pounds.
- 2- I have lost more than ten pounds.
- 3- I have lost more than fifteen pounds.

#20

- 0- I am no more worried about my health than usual.
- 1- I am worried about physical problems such as aches or pains, or upset stomach, or constipation
- 2- I am very worried about physical problems and it's hard to think of much else
- 3- I am so worried about my physical problems that I cannot think about anything else.

#21

- 0- I have not noticed any recent change in my interest in sex.
- 1- I am less interested in sex than I used to be.
- 2- I am much less interested in sex now.
- 3- I have lost interest in sex completely.

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Your Total Score = \_\_\_\_\_ Levels of Depression

1-10=These ups and downs are considered normal

11-16=Mild mood disturbance Borderline clinical depression Moderate

17-20=depression

21-30=Severe depression

31-40(+)=Extreme depression