



**Torrance Memorial Medical Center - Sleep Disorders Center**  
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**SLEEP & HEALTH QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

My main sleep complaint(s) are \_\_\_\_\_

\_\_\_\_\_

I have had this problem(s) since: \_\_\_\_\_

It is: \_\_\_\_\_ getting worse \_\_\_\_\_ staying the same \_\_\_\_\_ fluctuates

List all medication and dosages:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Social History: (circle one) single married separated divorced widowed

Alcohol: (check one)

- \_\_\_\_\_ Never
- \_\_\_\_\_ Rarely (1-2 drinks per week)
- \_\_\_\_\_ moderately (3-10 drinks per week)
- \_\_\_\_\_ more than 10 drinks per week
- \_\_\_\_\_ have or had problems with alcohol

Tobacco: (check one)

- \_\_\_\_\_ I do not smoke
- \_\_\_\_\_ I smoke cigarettes \_\_\_\_\_ packs/day
- \_\_\_\_\_ I use to smoke for \_\_\_\_\_ years, but quit \_\_\_\_\_ years ago.

Caffeine: cups per day I drink \_\_\_\_\_ coffee \_\_\_\_\_ tea \_\_\_\_\_ cola \_\_\_\_\_ None \_\_\_\_\_

Adult operation, diseases, injuries (include dates):

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Do you have high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you had tonsils or adenoids removed? Yes \_\_\_\_\_ No \_\_\_\_\_

My other important sleep complaints are: (check all that apply)

- \_\_\_\_\_ I have trouble sleeping at night.
- \_\_\_\_\_ I can sleep all day
- \_\_\_\_\_ I snore
- \_\_\_\_\_ I have unwanted behaviors when I am asleep.

Explain: \_\_\_\_\_  
\_\_\_\_\_

**SLEEP SCHEDULE:** (answer all questions)

On weekdays/workdays I usually go to bed at .....

On weekdays/workdays the earliest time in the last 2 weeks I've gone to bed \_\_\_\_\_

And the latest time was at .....

In the evening I usually start feeling sleepy at .....

The amount of time it usually takes to fall asleep is .....

On weekdays I wake up at .....

My usual weekend/days off bedtime is at .....

On weekends I wake up at .....

To feel my best I need \_\_\_\_\_ hours of sleep.

The number of times at night that I wake up are .....

The clock times that I wake up during the night are .....

The amount of time it takes me to go back to sleep is .....

The amount of time I am awake during the night after falling asleep is .....  
I urinate \_\_\_\_\_ times per night.

I wake up in the morning: \_\_\_\_\_ naturally \_\_\_\_\_ by alarm.

I take a nap \_\_\_\_\_ times per week.

After a nap I feel : \_\_\_\_\_ refreshed \_\_\_\_\_ sleepy/groggy.

I usually exercise at \_\_\_\_\_ o'clock for \_\_\_\_\_ minutes.

What is your job? \_\_\_\_\_

**I USUALLY WORK:** (check the choices that are true for you)

\_\_\_\_\_ day shift from \_\_\_\_\_ to \_\_\_\_\_ o'clock.

\_\_\_\_\_ evening shift from \_\_\_\_\_ to \_\_\_\_\_ o'clock.

\_\_\_\_\_ night shift from \_\_\_\_\_ to \_\_\_\_\_ o'clock.

\_\_\_\_\_ I rotate shifts every \_\_\_\_\_ days.

Comments: \_\_\_\_\_

\_\_\_\_\_

Commuting to and from work takes \_\_\_\_\_ minutes.

\_\_\_\_\_ I sometimes fly across time zones.

How often? \_\_\_\_\_ How many time zones? \_\_\_\_\_

**WHAT MY SLEEP IS LIKE :** (check the choices that are true for you)

\_\_\_\_\_ I have been told that I snore very loudly.

\_\_\_\_\_ Sometimes a person cannot sleep in the same room, because of my snoring.

\_\_\_\_\_ I have been told that I stop breathing when I sleep.

\_\_\_\_\_ I have been told that I gasp or snort when I sleep.

\_\_\_\_\_ I sweat a lot when I sleep.

\_\_\_\_\_ My bed covers are very messed up in the morning.

\_\_\_\_\_ I am a very restless sleeper.

\_\_\_\_\_ I sometimes awaken with a sour taste in my mouth.

\_\_\_\_\_ I sometimes get heartburn at night.

**MY USUAL SLEEPING POSITION:** (check the choices that are true for you)

\_\_\_\_\_ On my back

\_\_\_\_\_ On my side

\_\_\_\_\_ On my stomach

- \_\_\_\_\_ No single position is usual
- \_\_\_\_\_ I feel that the quality of my sleep is unsatisfactory.
- \_\_\_\_\_ I have been told that my legs twitch or jerk when I sleep.
- \_\_\_\_\_ I have been told that I make rolling or rocking movements when I sleep.
- \_\_\_\_\_ I have been told that I kick or poke my bed partner while I am sleeping.

**DURING THE FIRST 30 MINUTES AFTER WAKING UP IN THE MORNING  
I USUALLY FEEL :**

- \_\_\_\_\_ very groggy
- \_\_\_\_\_ somewhat drowsy
- \_\_\_\_\_ slightly drowsy, but awake
- \_\_\_\_\_ alert

**AS AN ADULT:**

- \_\_\_\_\_ My dreams often wake me.
- \_\_\_\_\_ I often have frightening dreams.
- \_\_\_\_\_ I have wet my bed.
- \_\_\_\_\_ I have been told that I bang or twist my head at night.
- \_\_\_\_\_ I have hallucinations or dream like images when I am not actually asleep, but while falling asleep or waking up.
- \_\_\_\_\_ I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness.
- \_\_\_\_\_ I have had the sensation of a sudden weakness in my legs while awake (This may occur particularly in emotional situations.)

**INSOMNIA:** (check the choices that are true for you)

- \_\_\_\_\_ I have trouble falling asleep at night.
- \_\_\_\_\_ When I wake up during the night, I have trouble going back to sleep.
- \_\_\_\_\_ Some nights, I never get to sleep, no matter how hard I try.
- \_\_\_\_\_ When I try to fall asleep I worry about whether or not I can go to sleep.
- \_\_\_\_\_ At night when I go to bed, I do not feel sleepy.
- \_\_\_\_\_ I often sleep better in an unfamiliar bedroom, such as a hotel.
- \_\_\_\_\_ When I wake up at night, I often watch the clock.

- \_\_\_\_\_ I wake up in the morning long before I have to.
- \_\_\_\_\_ Pain often wakes me up and keeps me from going back to sleep.  
Location of pain: \_\_\_\_\_
- \_\_\_\_\_ I often take sleeping pills in order to sleep.
- \_\_\_\_\_ I have a creeping, crawling sensation in my legs when I lie down to sleep.
- \_\_\_\_\_ Sensations in my legs keep me from falling asleep.
- \_\_\_\_\_ I am a very light sleeper, I awaken easily with noises.
- \_\_\_\_\_ My sleep is disturbed because of my bed partner.
- \_\_\_\_\_ Generally I get up in the middle of the night for a snack.
- \_\_\_\_\_ I have been depressed in the past.
- \_\_\_\_\_ I have had nervous breakdowns in the past.
- \_\_\_\_\_ I tend to be sad or depressed in the winter.
- \_\_\_\_\_ I am a “night person”.
- \_\_\_\_\_ I am a “morning person”.

**DAYTIME SLEEPINESS:** (check the choices that are true for you)

- \_\_\_\_\_ I have sometimes fallen asleep at very inappropriate times such as, in meetings.
- \_\_\_\_\_ I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.
- \_\_\_\_\_ Usually I find myself falling asleep during half-hour TV shows.
- \_\_\_\_\_ I am frequently so sleepy during the day that my work is poor.
- \_\_\_\_\_ I generally feel most tired/sleepy in the afternoon.
- \_\_\_\_\_ I often would like to take an afternoon nap even when I cannot.
- \_\_\_\_\_ I have “come to” and suddenly became alert and found myself doing things without being aware of having started them or how I got there.
- \_\_\_\_\_ I generally feel tired/sleepy all day.
- \_\_\_\_\_ I function best in the morning.
- \_\_\_\_\_ I function best in the evening.

\_\_\_\_\_ When I have no plans or appointments the next day, I frequently go to bed late.

\_\_\_\_\_ I frequently do not feel sleepy at bedtime and stay up until it is so late, that as a consequence, I get too little sleep.

\_\_\_\_\_ When I get a good nights sleep, I feel better the next day.

\_\_\_\_\_ Several times recently I got up later than planned, even though I went to bed at the right time.

\_\_\_\_\_ I would feel better if I slept at least one more hour every night.

\_\_\_\_\_ I like to sleep in the morning when I can.

\_\_\_\_\_ I feel that I sleep too little.

**SLEEP HISTORY:** (check the choices that are true for you, if possible ask your parents, or relatives to help you remember your childhood behavior)

\_\_\_\_\_ I sometimes wet the bed after the age of 6.

\_\_\_\_\_ As a child I sleepwalked.

\_\_\_\_\_ As a child I screamed in my sleep.

\_\_\_\_\_ Had frequent nightmares.

\_\_\_\_\_ I would grind my teeth in my sleep.

\_\_\_\_\_ I banged my head on the bed to sleep.

\_\_\_\_\_ My current sleep problems started in childhood.

\_\_\_\_\_ I used to fall asleep in school as a child/adolescent.

\_\_\_\_\_ I always had to fight the urge to sleep during my classes at school, when I was a child/adolescent.

\_\_\_\_\_ As a child I used to stay up late in the evening.

\_\_\_\_\_ I was told that I snored while sleeping.

\_\_\_\_\_ I was considered a hyperactive or hyperkinetic child or teenager.

**FAMILY HISTORY:** These questions apply to your extended family, such as parents Children, aunts, uncles etc. Relatives that are related by blood.

\_\_\_\_\_ A relative died from crib death or sudden infant death.

\_\_\_\_\_ Family that have been or are hyperactive or hyperkinetic as children.

## BECK SCALE

Please read each group of statements, and mark the statements that best describes the way you have been feeling the past week, including today. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements before making your choice.

1.    0    I do not feel sad  
      1    I feel sad  
      2    I am sad all the time and I cannot snap out of it  
      3    I am so sad that I cannot 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/nothing will 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 failure  
      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 do not enjoy things as much as I used to  
      2    I do not get satisfaction out of anything anymore  
      3    I am dissatisfied or bored with everything
  
5.    0    I do not feel 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 do not 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 do not feel disappointed in myself  
      1    I am disappointed in myself  
      2    I am disgusted with myself  
      3    I hate myself
  
8.    0    I do not feel that I am worse than anyone else  
      1    I am critical of myself for my weaknesses/mistakes  
      2    I blame myself all the time for my faults  
      3    I blame myself of everything bad that happens
  
9.    0    I do not have thought of killing myself  
      1    I have thoughts, but 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 do not 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 I do not cry, now even when I want to
11. 0 I am no more irritated now than I ever am  
 1 I get annoyed or irritated more easily than I used to  
 2 I feel irritated all the time  
 3 I do not get irritated at all by things that used to irritate me
12. 0 I have not lost interest in other people  
 1 I am less interested than I used to be  
 2 I have lost most of my interest  
 3 I cannot make decisions at all anymore
13. 0 I make decisions about as well as before  
 1 I put off making decisions  
 2 I have more difficulty making decisions  
 3 I cannot make decisions at all anymore
14. 0 I do not feel I look any worse than before  
 1 I worry that I look older/unattractive  
 2 I feel that there are permanent changes that make me look unattractive  
 3 I believe I look ugly
15. 0 I can work about as well as before  
 1 It takes extra effort to get myself going on things  
 2 I have to push myself very hard to do things  
 3 I cannot do any work at all
16. 0 I can sleep as well as before  
 1 I do not sleep as well as before  
 2 I wake up 1-2 hours earlier than usual and find it had 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 do not get more tired than usual  
 1 I get more tired than I used to  
 2 I get tired from doing almost nothing  
 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
19. 0 I have not lost much weight lately, if any  
 1 I have lost more than 5 lbs.  
 2 I have lost more than 10 lbs.  
 3 I have lost more than 15 lbs.

I am purposely trying to lose weight by eating less: YES \_\_\_\_\_ NO \_\_\_\_\_

20. 0 I am not worried about my health more than usual  
1 I am worried more than usual about things such as:  
Aches/pains, upset stomach, constipation  
2 I am worried about my health and it its hard to think about anything else  
3 I am so worried about my health 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 than I used to be  
2 I am much less interested in sex now  
3 I have lost all interest in sex

TOTAL: \_\_\_\_\_

## HAMILTON ANXIETY RATING SCALE

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This checklist is to assist the physician in evaluating each patient with respect to degree of anxiety and pathological condition. Please fill in the appropriate rating.

- 0 None
- 1 Mild
- 2 Moderate
- 3 Severe
- 4 Very Severe, incapacitating

<u>ITEM</u>	<u>RATINGS</u>	<u>ITEM</u>	<u>RATINGS</u>
<b>ANXIOUS MOOD</b> Worries, anticipation of the worst, Tearful anticipation, irritability		<b>SOMATIC (SENSORY)</b> Tinnitus, blurring of vision, hot & cold flashes, Feelings of weakness, pricking sensation	
<b>TENSION</b> Feelings of tension, startle response, Moved to tears easily, trembling Feelings of restlessness, inability to relax.		<b>CARDIOVASCULAR SYMPTOMS</b> Tachycardia, palpitations, pain in chest, Throbbing of vessels, missing beat.	
<b>FEAR</b> Of dark, of strangers, of being left alone, Of animals, of traffic, of crowds		<b>RISPIRATORY SYMTOMS</b> Pressure or constriction in chest Choking feeling, sighing, dyspnea	
<b>INSOMNIA</b> Difficulty in falling asleep, broken sleep, Unsatisfying sleep & fatigue on waking, Dreams, nightmares, night terrors		<b>GASTROINTESTINAL SYMPTOMS</b> Difficulty swallowing, wind, abdominal pain, burning Sensations, abdominal fullness, nausea, vomiting, looseness of bowels, loss of weight, constipation.	
<b>INTELLECTUAL (COGNITIVE)</b> Difficulty in concentration Poor memory		<b>GENITOURINARY SYMPTOMS</b> Frequency of nocturia, urgency of urination, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.	
<b>DEPRESSED MOOD</b> Loss of interest, lack of pleasure in hobbies Depression, early waking, mood swing		<b>AUTONOMIC SYMPTOMS</b> Dry mouth, flushing, pallor, tendency to sweat, Giddiness, tension headache, raising of hair	
<b>BEHAVIOR AT INTERVIEW</b> Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, Belching, brisk tendon jerks dilated pupils.		<b>SOMATIC ( MUSCULAR )</b> Pains & aches, stiffness, grinding of teeth, Unsteady voice, increased muscular tone.	

**TOTAL SCORE** \_\_\_\_\_