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240 Williamson St., Suite 300, Elizabeth, NJ 07202 Tel (908) 994-8880 · Fax (908) 994-8882



SLEEP QUESTIONNAIRE

PATIENT NAME _____ **DATE OF BIRTH** _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TO THE SLEEP CENTER? _____

HOW LONG HAS THIS PROBLEM AFFECTED YOU? _____

HOW SERIOUS IS THIS PROBLEM FOR YOU? (circle one below)

VERY SERIOUS MODERATELY SERIOUS MILDLY SERIOUS NOT SERIOUS

HAVE YOU EVER HAD A SLEEP STUDY BEFORE? YES NO

IF YES, WHAT WERE THE RESULTS? _____

SLEEP PATTERNS

WORK DAYS

OFF DAYS

ACTIVITY PRIOR TO TURNING LIGHT OFF TO SLEEP _____

TYPICAL BEDTIME (e.g. 10 PM) _____

TYPICAL TIME IT TAKES TO FALL ASLEEP (e.g. 15 minutes) _____

TYPICAL NUMBER OF AWAKENINGS _____

ACTIVITIES DURING AWAKENING (e.g. WATCHING TV, READING) _____

TYPICAL AMOUNT OF TIME NEEDED TO FALL BACK ASLEEP _____

TYPICAL WAKE UP TIME _____

DESIRED WAKE UP TIME _____

HOW DO YOU USUALLY AWAKEN? (e.g. ALARM CLOCK) _____

TOTAL AMOUNT OF SLEEP _____

NUMBER OF NAPS PER DAY _____

TYPICAL LENGTH OF NAP _____

DO YOU FEEL YOU GET TOO MUCH SLEEP AT NIGHT? YES NO

DO YOU FEEL YOU GET TOO LITTLE SLEEP AT NIGHT? YES NO

SLEEP HABITS

___ I FREQUENTLY TRAVEL ACROSS 2 OR MORE TIME ZONES

___ I USUALLY WATCH TV OR READ IN BED PRIOR TO SLEEP

___ I DRINK ALCOHOL PRIOR TO BEDTIME

___ I SMOKE PRIOR TO BEDTIME OR WHEN I AWAKEN DURING THE NIGHT

___ I EAT A SNACK AT BEDTIME

___ I HAVE TROUBLE FALLING ASLEEP

___ THOUGHTS RACE THROUGH MY MIND WHEN I TRY TO FALL ASLEEP

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- I HAVE EXPERIENCED WEAKNESS OR PARALYSIS WHEN GOING TO SLEEP
- I HAVE AN ACIDIC STOMACH WHEN I SLEEP
- I EXPERIENCE CREEPING, CRAWLING OR TINGLING SENSATION IN MY LEGS WHEN I TRY TO FALL ASLEEP
- I AWAKEN FREQUENTLY DURING THE NIGHT
- I AM UNABLE TO EASILY RETURN TO SLEEP IF I AWAKEN
- I AM HUNGRY WHEN I AWAKEN DURING THE NIGHT
- I WILL EAT SOMETHING IF I AWAKEN DURING THE NIGHT
- I TYPICALLY AWAKE TO URINATE DURING THE NIGHT
- I HAVE NIGHTMARES OR DISTURBING DREAMS
- I SWEAT A GREAT DEAL DURING SLEEP
- I EXPERIENCE IRREGULAR OR SUDDEN, FAST HEARTBEAT
- I CANNOT SLEEP ON MY BACK
- I AWAKEN EARLY, AND STILL TIRED, BUT UNABLE TO RETURN TO SLEEP
- I AWAKEN FROM SLEEP WITH A HEADACHE
- I HAVE EXPERIENCED WEAKNESS OR PARALYSIS ON AWAKENING
- I EXPERIENCE SEEING THINGS OR HEARING VOICES THAT ARE NOT REAL

BREATHING

- I HAVE BEEN TOLD THAT I SNORE
- I HAVE BEEN TOLD THAT I SNORE ONLY WHEN SLEEPING ON MY BACK
- I HAVE BEEN AWAKENED BY MY OWN SNORING
- I AWAKEN AT NIGHT CHOKING, SMOTHERING OR GASPING FOR AIR
- I HAVE BEEN TOLD THAT I STOP BREATHING WHILE ASLEEP

RESTLESSNESS

- I AM A RESTLESS SLEEPER
- I KICK OR JERK MY LEGS AND/OR ARMS DURING SLEEP
- I EXPERIENCE RESTLESSNESS, TINGLING OR CRAWLING SENSATION IN MY ARMS/LEGS
- I EXPERIENCE AN INABILITY TO KEEP MY LEGS STILL PRIOR TO SLEEP
- I TALK IN MY SLEEP
- I HAVE SLEEP WALKED AS AN ADULT
- I GRIND MY TEETH IN MY SLEEP
- I HAVE CHRONIC PAIN THAT PREVENTS ME FROM BEING COMFORTABLE TO SLEEP

DAYTIME SLEEPINESS

- I HAVE A TENDENCY TO FALL ASLEEP DURING THE DAY
- I HAVE EXPERIENCED LAPSES OF TIME OR BLACKOUTS
- I HAVE FALLEN ASLEEP WHILE DRIVING
- I HAVE HAD AUTO ACCIDENTS AS A RESULT OF FALLING ASLEEP

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- ___ I FALL ASLEEP WATCHING TV
- ___ I FALL ASLEEP DURING CONVERSATIONS
- ___ I FALL ASLEEP DURING SEDENTARY SITUATIONS
- ___ I PERFORM POORLY IN WORK/SCHOOL DUE TO SLEEPINESS
- ___ I HAVE EXPERIENCED SUDDEN MUSCLE WEAKNESS IN RESPONSE TO EMOTION SUCH AS LAUGHTER, ANGER, ETC.
- ___ I HAVE EXPERIENCED INABILITY TO MOVE WHEN FALLING ASLEEP OR AWAKENING
- ___ I FEEL VERY FATIGUED DURING THE DAY
- ___ I FEEL DEPRESSED DURING THE DAY

SOCIAL HABITS

DO YOU SMOKE? YES NO IF YES: AMOUNT _____ packs HOW MANY YEARS _____ yrs

DO YOU DRINK ALCOHOL? YES NO

IF YES: TYPE FREQUENCY AMOUNT PER WEEK

BEER DAILY WEEKENDS _____ cans/week

WINE DAILY WEEKENDS _____ glasses/week

LIQUOR DAILY WEEKENDS _____ shots/week

DO YOU USE COCAINE OR CRACK? YES NO

DO YOU USE "UPPERS OR DOWNERS"? YES NO

DO YOU SMOKE MARIJUANA? YES NO

DO YOU USE OTHER NON-PRESCRIBED DRUGS? YES NO

IF YES, PLEASE LIST _____

SOCIAL HISTORY

___ SLEEP ALONE ___ SHARE A BED WITH SOMEONE ___ SHARE A BEDROOM WITH SEPARATE BEDS

___ SHARE A BED WITH A PET ___ PROVIDE ASSISTANCE TO SOMEONE DURING THE NIGHT (e.g. child, invalid etc)

IS YOUR SLEEP OFTEN DISTURBED BY? ___ HEAT ___ COLD ___ NOISE ___ BED PARTNER ___ LIGHT ___ OTHER

WHAT IS YOUR HEIGHT? _____ YOUR WEIGHT? _____

WHAT WAS YOUR WEIGHT ONE YEAR AGO? _____ FIVE YEARS AGO? _____

FOR EACH BEVERAGE LISTED, WRITE IN THE AVERAGE NUMBER YOU DRINK PER DAY

REGULAR COFFEE _____ CUPS A DAY

DECAFFEINATED COFFEE _____ CUPS A DAY

TEA _____ CUPS A DAY

SOFT DRINKS WITH CAFFEINE _____ CANS A DAY

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EMPLOYMENT STATUS

- EMPLOYED UNEMPLOYED RETIRED STUDENT

IF EMPLOYED, WHAT ARE YOUR TYPICAL WORKING HOURS? _____

___ MY JOB REQUIRES DRIVING A VEHICLE

___ I AM WORKING WITH DANGEROUS EQUIPMENT OR SUBSTANCES

___ I AM A SHIFT WORKER ON ROTATING SHIFTS

___ I AM A PERMANENT OR LONG TERM THIRD SHIFT (MIDNIGHT) WORKER

___ IF A STUDENT, WHAT GRADE OR LEVEL ARE YOU IN _____

EPWORTH SLEEP SCALE

The questions below are designed to assist us with evaluating your sleepiness during routine activities. Please answer these questions to the best of your ability. Even if you have not performed some or all of these activities, how do you think you would feel if you had? The question is asking you, how big is your chance of falling asleep during that situation.

Choose from the following scale, the most appropriate number for each situation:

- 0 = would NEVER fall asleep
- 1 = SLIGHT chance of falling asleep
- 2 = MODERATE chance of falling asleep
- 3 = HIGH chance of falling asleep

<i>Situations</i>	<i>Chance of Falling Asleep</i>
a) Sitting and Reading	_____
b) Watching TV	_____
c) Sitting, inactive in a public place (i.e. a theater or meeting)	_____
d) As a passenger in a car for an hour without a break	_____
e) Lying down to rest in the afternoon	_____
f) Sitting and talking with someone	_____
g) Sitting quietly after a lunch without alcohol	_____
h) In a car, while stopped for a few minutes in traffic	_____

TOTAL SCORE : _____