SLEEP MEDICINE & RESEARCH CENTER
مركز طب وبحوث النوم

KAUH
مستشفى جامعة الملك عبدالعزيز
King Abdulaziz University Hospital

QUESTIONS ABOUT YOUR BEHAVIOR DURING SLEEP AND WAKE TIMES

NAME : _____ DATE :_____

MAIN SLEEP COMPLAINT : _____

١- How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.
(Use the following scale to choose the most appropriate number for each situation)

٠ - would never doze
١ - slight chance of dozing
٣ - moderate chance of dozing
٤ - high chance of dozing

Situation	Chance of Dozing (number)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (in a theater or in a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in a traffic	
TOTAL	

٢- What time do you go to bed ? _____

٣- How long does it take you to fall asleep (minutes) ? _____

٤- Do you take a sleeping pill to help you fall asleep or stay asleep ? ( ) YES ( ) NO
If yes do you know the name of it ? _____

٥- What time do you get up in the morning ? _____

٦- Do you know if you :
Snore : ( ) Always ( ) Sometimes ( ) Never Since When ? _____
Stop breathing : ( ) YES ( ) NO Since When ? _____
Wake up a lot at night : ( ) YES ( ) NO
Since When ? _____ For what reason ? _____
Do you dream while falling asleep ? ( ) YES ( ) NO since when ? _____

٧- Do your legs ever get restless – you feel like you need to get up and walk around ?
( ) Every night ( ) Occasionally ( ) Never

٨- Do your legs ever feel hot , burny , itchy , or like something is crawling on your skin when you are trying to sleep ?
( ) Every night ( ) Occasionally ( ) Never

٩- Do you ever wake up and feel paralyzed ?
( ) Every night ( ) Occasionally ( ) Never

١٠- When you are angry or excited or laughing , do you feel a generalized sensation of weakness and especially at the knees ?
( ) Every night ( ) Occasionally ( ) Never

١١- Do you nap ?
( ) Every night ( ) Occasionally ( ) Never
If yes : ( ) accidentally OR ( ) purpose

١٢- Do you dream when you nap ?
( ) Better ( ) Worse ( ) No difference

١٣- How do you feel after a nap ?
( ) Every night ( ) Occasionally ( ) Never

١٤- Do you ever wake up with (Check only those which apply to you) ?

Condition	Yes	No
An acidic taste in your mouth		
Chocking feeling		
Your heart racing		
Headaches		
Short of breathe		

١٥- How much coffee/tea/cola do you drink per day ?

Type of Drink	Number of Cups
Coffee	
Tea	
Cola	

١٦- Do your ankles ever swell up ? ( ) YES ( ) NO If yes , since when ? _____

١٧- Has your nose ever been broken ? ( ) YES ( ) NO If yes , when ? _____

١٨- Can you breathe well through both nostrils ? ( ) YES ( ) NO

١٩- Do you have any medical problems we should be aware of ?
(Example: diabetes, thyroid deficiency, heart problems, etc.)

_____

_____

_____

_____

٢٠- Do you take any medication ?
If yes please list all medications you are currently taking :

Medication	Dosage	Reason	Since when

Bed Partner Questionnaire

NAME : _____ MRN: _____ DATE : _____

NAME OF PARTNER : _____

YOUR RELATIONSHIP TO PATIENT : _____ MOBILE : _____

١-How often have you observed this person's sleep ?

( ) Never ( ) Once or Twice ( ) Often ( ) Every night

٢-What behaviors have you observed in this person while he or she was asleep ?

Behaviors	Every Night	Occasionally	Never
Light snoring			
Loud snoring			
Lose of consciousness			
Pauses in breathing			
Leg kicking			
Teeth grinding			
Sleepwalking			
Arm twitching			
Bedwetting			
Screaming			
Sitting up in bed			
Awakening with pain			
Head rocking / banging			
Sleeping even if seems awake			

OTHER : _____

_____

٣-Has this person fallen asleep during normal daytime activities or in dangerous situations ? ( ) YES ( ) NO

If yes, explain : _____

_____