UNIVERSITY of MARYLAND MEDICAL SYSTEM

This questionnaire will provide information about your sleep problem to our Sleep Specialist for a better understanding of your complaint. Please answer each question as completely as possible and circle questions that you would like to discuss in further detail with the physician.

Date Completed: _____

Patient Name: _____ Age: _____ Gender: ☐ Male ☐ Female

SS#: _____ Date of Birth: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Shirt Collar Size: _____

Home Phone: _____ Cell Phone: _____

Referring Physician: _____

Please give a brief description of the symptoms that are concerning for a sleep disorder (poor sleep quality, sleepiness, etc.)

_____

_____

_____

_____

_____

How long have these symptoms been a problem?

A. SLEEP HISTORY (may elaborate in space provided at the end of this section)

1. What time do you go to bed on weekdays? _____ AM/PM On weekends? _____ AM/PM
2. What time do you wake up on weekdays? _____ AM/PM On weekends? _____ AM/PM
3. When you go to bed, how long does it usually take to fall asleep? _____ Minutes
4. How many times do you awaken on an average night? _____ times.
5. When awakenings occur, are they associated with:
   - ☐ the need to urinate
   - ☐ snoring
   - ☐ pain
   - ☐ difficulty reinitiating sleep
   - ☐ gasping or choking
6. Upon your final awakening, do you experience:
   - ☐ feeling of refreshment
   - ☐ headache
   - ☐ sleepiness / fatigue
   - ☐ mouth or throat dryness or irritation
7. On the average, how long are you awake in the morning before you actually get out of bed? _____ Mins.

Pateint Name:_____ Date of Birth:_____

A. SLEEP HISTORY (Cont'd)

8. Do you take naps during the day? ☐ Yes ☐ No
   If yes, what time? _____ For how long? _____ Minutes
9. Does your bed partner describe:
   ☐ Snoring ☐ Limb jerking
   ☐ Pauses in breathing pattern (apneas) ☐ "Restlessness" with tossing and turning
10. Do you feel that you suffer from insomnia? ☐ Yes ☐ No
    (If yes, please describe below)
11. What position do you usually sleep in?
    ☐ On Side ☐ On stomach
    ☐ On back ☐ Combination of all three
12. Have you ever had a previous sleep study? ☐ Yes ☐ No
    If so, when? _____ Where? _____
13. Have you ever used nasal CPAP therapy? ☐ Yes ☐ No
    Duration of treatment? _____ Pressure setting: _____
    Have you ever used nocturnal oxygen therapy? ☐ Yes ☐ No

Additional Information:

_____

_____

_____

B. SLEEPINESS

1. Do you wake feeling tired or wanting more sleep regardless of how much sleep you get?
   ☐ Yes ☐ No ☐ Sometimes
2. Do you struggle to stay awake during the day? ☐ Yes ☐ No ☐ Sometimes
3. Have you ever dozed off while driving? ☐ Yes ☐ No
4. Do you fall asleep easily in social situations or meetings? ___ Yes No ☐ Sometimes
5. Do you have feelings of depression throughout the day? ___ Yes No ☐ Sometimes
6. Do you have difficulty concentrating during the day? ___ Yes ___ No ☐ Sometimes
7. Do you believe you have had a change in personality or increased irritability over the past year?
   ☐ Yes ☐ No ☐ Sometimes
8. Do you believe your "efficiency" performing at work or other tasks is affected by your sleepiness?
   ☐ Yes ☐ No ☐ Sometimes
9. Do you feel a lack of energy or fatigue throughout the day? ☐ Yes ☐ No ☐ Sometimes

Pateint Name:_____ Date of Birth:_____

B. SLEEPINESS (Cont'd)

10. Have you had:

Loss of sexual interest/libido? ☐ Yes ☐ No ☐ Sometimes

Erectile dysfunction? ☐ Yes ☐ No ☐ Sometimes

Menopausal Status: Yes No Perimenopause

Additional Information:

_____

_____

_____

C. SLEEP QUALITY

1. Do you experience dreams? ☐ Yes ☐ No ☐ Sometimes ☐ Infrequently
2. Do you experience night mares? ☐ Yes ☐ No ☐ Sometimes ☐ Infrequently
3. Do your legs or arms bother you when resting or falling asleep or feel "restless" during the day?

   ☐ Yes ☐ No ☐ Sometimes
4. Do you grind your teeth during sleep? ☐ Yes ☐ No ☐ Sometimes
5. Do you have any unusual sleep behavior (sleep walking, sleep talking)?

   ☐ Yes ☐ No
6. Have you ever awoken from sleep with a feeling of muscular paralysis?

   ☐ Yes ☐ No
7. Have your dreams ever been so vivid that there was doubt upon awakening whether this was a dream or reality (even hours after awakening)? ☐ Yes ☐ No
8. Have you ever developed muscular paralysis during wakefulness (particularly with periods of laughter or excitement)? ☐ Yes ☐ No

D. MEDICAL HISTORY (please describe positive answers in space provided at the end of section)

1. Do you have a history of any of the following:
   - ☐ Arthritis or fibromyalgia
   - ☐ Cardiac problems or chest pain
   - ☐ Diabetes
   - ☐ Depression or any previous history of requiring care of psychiatrist
   - ☐ Head injury
   - ☐ High blood pressure
   - ☐ Kidney problems
   - ☐ Nasal or sinus problems
   - ☐ Shortness of breath or lung disease
   - ☐ Seizures
   - ☐ Stroke

Pateint Name:_____ Date of Birth:_____

D. MEDICAL HISTORY (Cont'd)

2. Please list major medical problems not listed above for which you are followed by a physician or are receiving treatment.

3. Please list any operations you have had including any related to your nose or throat (including tonsillectomy).

4. Please list any medication you take on a regular basis (including sleep aids/stimulants).

Name	Dose	Reason for Taking

5. Please list allergies:

6. Please list any family medical history to any sleep disorders such as snoring, Sleep Apnea, Insomnia, and Narcolepsy.

7. Family History: ☐ Mother ☐ Alive ☐ Deceased Diagnosis _____
   ☐ Father ☐ Alive ☐ Deceased Diagnosis _____

8. a. What is your occupation? _____

   b. What hours do you work? _____

9. Have you ever worked shift work? ☐ Yes ☐ No

Patient Name:_____ Date of Birth:_____

D. MEDICAL HISTORY (Cont'd)

Additional Information:

_____

_____

_____

E. HABITS AFFECTING SLEEP (please further describe below if needed)

1. On the average, how many caffeinated beverages do you consume per week? _____
2. Do you use any over the counter caffeine products to maintain wakefulness? ☐ Yes ☐ No
3. Do you exercise regularly? ☐ Yes ☐ No
4. Do you take any hypnotic medications to help initiate sleep? ☐ Yes ☐ No
5. Do you have a history of smoking? ☐ Yes ☐ No

   If yes, how many cigarettes do you smoke per day? _____

   How long have you been smoking? _____
6. Do you currently smoke? ☐ Yes ☐ No
7. On the average, how many alcoholic beverages do you consume per week?
8. Have you had any recent change in body weight? ☐ Yes ☐ No

   Gained _____ Lbs. Lost _____ Lbs. Over what period of time? _____
9. Are there any distractions in your sleep environment (awakening children, nose, phone calls, etc.)? ☐ Yes ☐ No

Additional Information: _____

_____

_____

F. SYSTEM REVIEW (Please check if you experience any of the following):

☐ Chest Pain	☐ Shortness of breath/wheezing
☐ Dizziness	☐ Cough
☐ Palpitations	☐ Heartburn or reflux
☐ Blackout spells	☐ Nasal congestion
☐ Headaches	☐ Trouble swallowing
☐ Visual changes	☐ Joint or muscle pain
☐ Urinary problems	☐ Leg or ankle swelling
☐ Constipation/diarrhea	☐ Calf pain with walking

Patient Name:_____ Date of Birth:_____

EPWORTH SLEEPINESS SCALE (ESS)

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* of each situation.

0 = Have never done

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____

Pateint Name:_____ Date of Birth:_____

H. SLEEP APNEA RISK

1. Do you have a history or snoring?
   ☐ No = 0 ☐ Mild/Infrequent = 0 ☐ Moderate/Inconsistent = 2 ☐ Sever/Consistent = 8

2. Have you ever been told that you have "pauses" in breathing during sleep?
   ☐ No = 0 ☐ Yes/Infrequent = 2 ☐ Inconsistent, but most nights = 8 ☐ Severely so = 10

3. Are you overweight?
   ☐ No = 0 ☐ <20 lbs = 2 ☐ Between 20 – 50 lbs = 3 ☐ >50 lbs = 8

4. Evaluate your sleepiness from the ESS Score on the previous page.
   ☐ ≤8 = 0 ☐ 9-13 = 1 ☐ 14-18 = 6 ☐ ≥ 19 = 8

5. Does your medical history include:
   - ☐ High blood pressure = 6
   - ☐ Heart Disease = 1
   - ☐ >3 awakenings/sleep period = 4
   - ☐ Depression = 1
   - ☐ Stroke = 1
   - ☐ Morning Headaches = 1
   - ☐ Excessive Fatigue = 1
   - ☐ Diabetes, even borderline = 1

Total Score (Add each response above) _____

Patient Name:_____ Date of Birth:_____

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ-10)

Patient Name:	**Referring Provider:**
Date of Birth:	**Today's Date:**

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do **not** refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put a check in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible.

4 = NO difficulty
3 = YES, a little difficulty
2 = YES, moderate difficulty
1 = YES, extreme difficulty

	Degree of Difficulty			
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
2. Do you generally have difficulty remembering things because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
3. Do you have difficulty operating a motor vehicle for **short** distances (less than 100 miles) because you become sleepy?	☐ 4	☐ 3	☐ 2	☐ 1
4. Do you have difficulty operating a motor vehicle for **long** distances (greater than 100 miles) because you become sleepy?	☐ 4	☐ 3	☐ 2	☐ 1
5. Do you have difficulty visiting your family or friends in **their** home because you become sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
7. Do you have difficulty watching a movie or video because you become sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
8. Do you have difficulty being as active as you want to be in the **evening** because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
9. Do you have difficulty being as active as you want to be in the **morning** because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1
10. Has your mood been affected because you are sleepy or tired?	☐ 4	☐ 3	☐ 2	☐ 1

Thank you for completing this questionnaire.

Pateint Name:_____ Date of Birth:_____

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ-10)
Scoring Instructions

Subscales	**#Questions**	**Item #**
General Productivity (GP)	2 questions	1, 2
Social Outcome (SO)	1 question	5
Activity Level (AL)	3 questions	6, 8, 9
Vigilance (V)	3 questions	3, 4, 7
Intimate Relationships and Sexual Activity (IR)	1 question	10

Subscale Scores: Calculate the average of the answered items for each subscale. This is the weighted mean item total or subscale score. Subscale scores average from 1-4.

To obtain a Total Score: Add the 5 subscales to produce a total score. Total scores range from 5-20.

SCORING WORKSHEET

	Degree of Difficulty			
Subscales	**Answer Item A**	**Answer Item B**	**Answer Item C**	**Average**
GP	**Q1:**	**Q2:**		
SO	**Q5:**			
AL	**Q6:**	**Q8:**	**Q9:**	
V	**Q3:**	**Q4:**	**Q7:**	
IR	**Q10:**			
			Total Score	

SCORE INTERPRETATION

Score Range = 5 to 20 points, with higher scores indicating better functional status.
Untreated sleep apnea patients **Score Range = 12.48 ± 3.23**
Controls without sleep disorders **Score Range = 17.81 ± 3.10**

Citation: Chasens ER; Ratcliffe SJ; Weaver TE. Development of the FOSQ-10: a short version of the functional outcomes of sleep questionnaire. SLEEP 2009;32(7):915-919.