# SLEEP DISORDERS QUESTIONNAIRE	SURNAME Mr/Mrs/Miss	
	FIRST/MIDDLE NAMES	
	DOB	CASE No.

Date		**Your Mobile number:**
Your home telephone Number		

Are you happy for messages to be left on your answerphone?	**Mobile**: Yes/No; **Home**: Yes/No

Why this questionnaire? We are receiving an increasing number of referrals for suspected sleep apnoea. To reduce long waiting, we have changed our pathway for managing patients with sleep complaints.

Currently we invite all patients with suspected sleep apnoea for a 'Home Sleep Apnoea Test'. In addition, to make a correct diagnosis and plan treatment, we need to know your sleep-wake symptoms, sleep routines & habits, medical history, current medications, personal, family and work history. We gather the necessary information through this questionnaire, instead of a clinical consultation. Therefore **it is essential that you complete this questionnaire as completely and accurately as you can. If you do not complete this questionnaire, it is likely to delay the diagnosis and treatment.**

It will take you about 40-60 minutes to complete this questionnaire. If you find some questions ambiguous or difficult to answer, please add **additional information, comments or criticisms on page 16. Please ask your partner to complete pages 17-18.**

The questionnaire and the result of the sleep study are reviewed by a sleep professional. If you have moderate or severe Obstructive Sleep Apnoea (OSA) you will be offered treatment with CPAP (Continuous Positive Airway Pressure) therapy. You will be called to a group session for initiating treatment.

Do you have objection in attending a group session for starting therapy?	**Yes**	**No**
Many patients with sleep disorders are unaware of their symptoms. Do you experience any problems relating to your sleep?	**Yes**	**No**

	Below is a list of the most common symptoms of sleep disorders. Please indicate if you have any of the symptoms.	**Do you have this symptom?**	**Order of importance to you**
1.	Do you know or have you been told that you **snore** loudly (louder than talking or loud enough to be heard through closed doors)?	Yes / No	
2.	Do you often feel **tired or fatigued** during the daytime?	Yes / No	
3.	Do you often feel **sleepy** during the daytime?	Yes / No	
4.	Has anyone observed you **stop breathing** during sleep?	Yes / No	
5.	Do you have or are you being treated for **high blood pressure**?	Yes / No	
6.	Do you get **uncomfortable sensations or an urge to move** your legs or arms in the evening and or night?	Yes / No	
7.	Do you suffer from **'Insomnia'** – (Difficulty in falling asleep, staying asleep, waking up too early or feeling not satisfied with sleep)	Yes / No	
8.	Do you feel **refreshed upon waking up after sleep?**	Yes / No	
9.	Do you have **Sleep walking, sleep terrors, or sleep eating**?	Yes / No	
10.	Do you **act out your dreams**?	Yes / No	

11.	**If you have answered YES to any of Questions 1 to 4** (i.e., snoring, stopping breathing during sleep and or tiredness, fatigue or sleepiness in the daytime), **please answer these questions:**		
	How long have you been snoring?	………. years	
	Do you wake up with choking, or gasping	Yes	No
	Do you wake up with a dry mouth?	Yes	No
	Do you wake up with night sweats?	Yes	No
	Are you restless in your sleep?	Yes	No
	Do you get 'heartburn' or 'acid reflux' during sleep?	Yes	No
	Do you suffer from morning headaches?	Yes	No
	Has there been a decrease in your 'sex drive' (libido) since your problems started?	Yes	No
	How many times in the night do you wake up to pass urine		
12.	**If you answered YES to question 6, please answer these questions**		
	When feeling an urge to move, **do you experience unpleasant sensations in your legs such** as itching, stabbing, pulling, crawling or pain?	Yes	No
	Does your urge to move/unpleasant sensations **begin or worsen when you are at rest** (lying, sitting) or when you are inactive?	Yes	No
	Are urges to move/unpleasant sensations **worse in the evening or at night** than during the day? (This means that the complaints occur only in the evening or at night or are worse at night than during the day).	Yes	No
	Is the urge to move/unpleasant sensations **relieved partially or completely by movement** such as walking or stretching?	Yes	No
	How long have you had these symptoms?	……..years	
	Did you suffer from 'growing pains' when you were a child?	Yes	No
	On average, how many nights a week do you get these symptoms?		
	What time do these symptoms start?	Morning / Afternoon / early evening / late evening / Sleep time	
	What do you believe is causing these symptoms?		
13.	**Do you get leg muscle cramps in your sleep time?**	Yes	No

14.	**If you have insomnia (i.e.,** difficulty in falling asleep, staying asleep, waking up too early or not being satisfied with sleep), **please rate how severe it is:**					
	Difficulty in falling asleep.	0=None	1=mild	2=moderate	3=severe	4=very severe
	Difficulty in staying asleep.	0=None	1=mild	2=moderate	3=severe	4=very severe
	Waking up too early and not being able to go back to sleep.	0=None	1=mild	2=moderate	3=severe	4=very severe
	How satisfied are you with your current sleep pattern?	0=very satisfied	1=satisfied	2=neutral	3=dissatisfied	4=very dissatisfied
15.	Do you feel refreshed after sleep?				Yes	No
16.	Do you grind your teeth in sleep?				Yes	No
17.	Do you talk in your sleep?				Yes	No

Do you have or have you been told that you have any of the following Symptoms? Please **check** [✓] the appropriate box.						
0 = Never 1 = Occasionally (once or twice a month or less) 2 = Sometimes (once or twice per week)		3 = Often (3-5 times a week) 4 = Always (almost daily)				
SLEEP-WAKE SYMPTOMS – (Continued...)		0	1	2	3	4
18.	**Do you know, OR have you been told OR have you found evidence of having performed any of the following in your sleep?**					
	Sleep walking.					
	Wake up in a different place than where you fell asleep.					
	Violent behaviour causing injury to yourself or bed partner or others.					
	Abruptly sitting up in bed filled with fear/terror and screaming, breathing fast and heart pounding.					
	Eat during your sleep without being aware.					
	Engage in sexual activity in sleep without being aware.					
19.	**Have you ever been told, or suspected yourself, that you seem to 'act out your dreams' while asleep** (for example, punching, flailing your arms in the air, making running movements, etc.)?					
20.	**Do you ever move so much during your sleep** that you accidentally hit your bed partner or hurt yourself?					
21.	Do you suffer from **frequent frightening dreams?**					
	Do these frightening dreams cause distress for you on the following day?					
22.	Have you had **"near-misses"** while driving?					
23.	Do you see dreamlike images (or hallucinations) upon falling asleep or waking up?					
24.	Do you feel paralysed and unable to move or talk upon falling asleep or upon awakening (sleep paralysis)?					
25.	Do you get irresistible urge to sleep during the daytime?					
26.	Have you ever engaged in activities in your wake time, of which you had little or no recollection later? (These are probably instances of Automatic Behaviour)					

27.	Have you **EVER** experienced **sudden muscle weakness when you laugh or are taken by surprise?** (Examples would include going weak at your knees, sagging of the jaw, head nodding etc.)		**NO → please go to the next page.**
	If your answer to the above is **YES**, during your episodes of muscle weakness,		
a	…can you hear?	Yes	No
b	…does your speech ever become slurred?	Yes	No
c	…is your head affected?	Yes	No
d	…is your whole body affected?	Yes	No

SECTION-II PLEASE TELL US ABOUT YOUR SLEEP SCHEDULE:

1.	Do you consider yourself to be a morning person ("early bird") or an evening person ("night owl") or neither?	Early Bird	Night owl	Neither
2.	Considering the question above, how strong is your preference?	Strong	Some	None

YOUR SLEEP TIMING: (this will vary depending on whether you are in work or not)

Do you always work in the day and sleep at night?		Do shift work		Not in work		Retired	

If you are a shift worker, please answer question 3. If not, go to question 4.

3.	**If you ARE A SHIFT WORKER, what shift pattern do you most often work?**	
	Day shift (approx. 7:00 a.m. to 3:00 p.m.	
	Evening shift (approx. 3:00 p.m. to 11 p.m.)	
	Night shift (approx. 11:00 pm to 7:00 a.m.)	
	Other: please describe:	
4.	**At what time do you usually go to bed?**	
	On a weekday/workday or school day	
	On a weekend/non-work or non-school day	
5.	**About how many minutes does it usually take for you to fall asleep?**	
	On a weekday/workday or school day	
	On a weekend/non-workday or non-school day	
6.	**At what time do you usually wake up? (i.e., FINAL** awakening from sleep**)**	
	On a weekday/workday or school day	
	On a weekend/non-work or non-school day	
7.	***Thinking of periods when you do not have to maintain a strict schedule*** (i.e., not bound by strict work or school schedule, such as while on holidays, or if you are retried or not working).	
	At what time do you usually go to sleep?	
	At what time do you usually wake up?	
	Are these sleep and wake times always the same?	Yes / No

YOUR **SLEEP REGULARITY:**

8.	**Do you usually follow the same sleep schedule on both work/school and non-work/non-school days** (i.e., no more than one hour difference in sleep and wake times)?	Yes	No

YOUR **SLEEP DURATION:**

9.	**How long do you spend in bed each night/day?** (this is the time from first lying in bed to the time you finally get out of bed)	
	On a workday or school day	
	On a non-workday or non-school day (i.e., weekend)	
10.	**How much sleep do you usually get during a typical night**	
	On a workday or school day	
	On a non-workday or non-school day (i.e., weekend)	
11.	**How many hours of sleep per night do you think you need to feel fully rested the next day?**	Hours minutes

SECTION-III **WAKING UP** from your main sleep period:

1.	Do you use an alarm to wake you up in the morning?	Never	Sometimes	Always
	Do you have great difficulty waking up in the morning?	Never	Sometimes	Always
	Do you often have so much trouble waking up that an alarm clock won't wake you and you have to use other methods to wake up?	Never	Sometimes	Always
	If you do, please give details:			
2.	**How long does it take you to become fully awake from regular sleep** (i.e., after first opening your eyes)?	hours	min	
3.	**When you wake up in the morning or from a nap, do you feel "out of it" or dazed or confused?**	Never	Sometimes	Always

4.	**How often do you feel awake and refreshed after sleeping?**									
	0-1 day/week		2-3 days/week		3-4 days/week		5-6 Days/week		Always	
5.	**How satisfied are you with your sleep?**									
	Very satisfied		Satisfied		Reasonably satisfied		Not satisfied		Very dissatisfied	

SECTION-IV YOUR ROUTINES & HABITS AROUND SLEEP:

Describe what you typically do within four hours before going to bed (e.g. exercise, eat/drink, watch TV, etc)	
What time do you have your last cup of coffee, tea, cola?	
If you drink alcohol, when do you have your last drink?	
If you are a smoker, what time do you have your last smoke?	

Do you exercise in the four hours before going to bed?	No	Yes
Do you do important work before going to bed?	No	Yes
Do you sleep in the living room /downstairs before going up to the bed room?	No	Yes

YOUR BEDROOM:

Where in the house do you sleep?	Bedroom	living room	Other:

Do you have blackout blinds in your bedroom?	Yes	No
Do you have any lights on in the bed room during your sleep time?	No	Yes
Is there noise in your neighbourhood that disturbs your sleep?	No	Yes

WHAT YOU DO IN BED:

Do you think or plan in bed?	No	Yes
Do you watch TV in bed?	No	Yes
Do you watch DVDs or play Game consoles just before you sleep?	No	Yes
Do use computer, laptop, tablet, or mobile phone to read or do work in bed?	No	Yes
Do you share your bed with a partner?	Yes	No
Do you share your bed or bedroom with any pets, e.g. dog, cat?	No	Yes

SECTION-V YOUR SLEEP PERIOD:

1.	Do you wake up between falling asleep and finally waking up in the morning?	No	Yes
2.	If so, on average, how many times do you remember waking up in your sleep period?		

3. If you wake up during your sleep period, please tell us why and how often.

Reason for waking up	**This is not a problem for me.**	**If this problem wakes you up from sleep, please state:** How many **TIMES A NIGHT** do you wake up due to this?	How many **NIGHTS A WEEK** does it wake you?
Noise in the neighbourhood			
Bedroom is too bright			
The bed is uncomfortable			
The bed room is too hot			
The bed room is too cold			
Snoring			
Choking sensation			
Gasping for breath			
To pass urine			
Breathlessness			
Cough, Wheeze			
Pain (joint pain, other pain)			
Muscle Cramps			
Heartburn or acid regurgitation			
To use medication			
Thoughts racing through mind			
Worrying about something			
Discomfort in legs/ arms			
Leg movements/leg kicking			
Bad dreams			
Others – please describe			

4.	**If you wake up, is it easy for you to return to sleep again?**	Yes	No		
5.	Typically, how long does it take you to fall asleep again?	hours	minutes		
6.	If you wake up during the night, how long are you awake for in total (add all the awakenings).	0-15 min	16-30 min	31-45 min	Longer: min

FOR WOMEN: SLEEP DURING MENSTRUAL PERIOD AND PREGNANCY:

Are/were there any differences in your sleep pattern during your periods/pregnancy?

SECTION-VI YOUR WAKE TIME (i.e., DAYTIME , unless you are a **shift worker**)

1.	**Do you feel fully alert and awake through the day?**	Yes	No
2.	**Do you feel excessively sleepy in the day?**	No	Yes
	Do you feel so sleepy during the day that it interrupts your normal activities – such as reading, or concentrating at work or school, even when you have had enough sleep the night before?	No	Yes
	Do you tend to fall asleep without any premonition?	No	Yes
3.	**Have you had trouble staying awake in the following situations?**		
	While in a theatre or at the cinema	No	Yes
	While attending a meeting	No	Yes
	While eating food	No	Yes
	While standing idle or walking	No	Yes

4.	**How often do you take naps in the day time?**									
	Never		Once a month or less		Once a week or less		1-2 per week		On most days	

	At what times of the day do you usually take naps? List up to three times per day:			
	How many hours and minutes of sleep do you usually get from a**ll your naps?**			
	Do you have great difficulty waking up from naps?	Never	Sometimes	Always
	Do you feel refreshed after a nap?	Never	Sometimes	Always
5.	**Do you feel tired or fatigued or "lack energy" in your wake time?**		No	Yes

	Do you do any of the following to overcome tiredness/fatigue?		
	Take energy drinks	No	Yes
	Drink coffee or tea	No	Yes
	Lie down to rest in the day time	No	Yes
	Reduce your physical activity	No	Yes
	Other (please specify)	No	Yes
6.	**Do you do any of the following to keep awake while driving?**		
	Turn up the volume of the radio in the car?	No	Yes
	Wind down the windows?	No	Yes
	Pull out of traffic and take nap?	No	Yes

7.	**To what extent has the sleep problem affected your:**					
	Alertness and ability to stay awake.	Not at all	A little	Somewhat	Much	Very much
	Attention and concentration.	Not at all	A little	Somewhat	Much	Very much
	Memory.	Not at all	A little	Somewhat	Much	Very much
	Mood – anxious/depressed.	Not at all	A little	Somewhat	Much	Very much
	Behaviour – such as becoming more irritable, snappy etc.	Not at all	A little	Somewhat	Much	Very much
	Energy and productivity.	Not at all	A little	Somewhat	Much	Very much
	Any other aspect of your life ( )					
8.	**Impact on your partner's sleep**					

SECTION VII

PREVIOUS MEDICAL PROBLEMS: Please tick mark **ONLY the items that apply to you.**

Pease leave all others blank.

No.	Item			Item		
1.	Stroke			Meningitis		
	Parkinson’s disease			Encephalitis		
	Epilepsy			Chronic pain disorder		
	Chronic Headache			Peripheral neuropathy		
	Head injury			Dementia		
2.	Angina					
	Heart attack					
	Heart failure					
	Atrial fibrillation					
	High blood pressure					
	Heart surgery					
3.	Asthma					
	COPD, emphysema or chronic bronchitis					
4.	Acid Reflux					
	Hiatus hernia					
	Peptic ulcer disease					
	Irritable bowel syndrome					
	Crohn’s disease or Ulcerative colitis					
	Coeliac disease					
5.	Kidney failure					
	Prostatic enlargement					
	Urinary Incontinence					
	Bed wetting					
6.	Underactive thyroid					
	Overactive thyroid					
	Diabetes mellitus (“sugar diabetes”)					
7.	Obstructive sleep apnoea					
	Restless Legs syndrome					
	Tooth grinding in sleep					
	Any other sleep disorder					
8.	Hay-fever					
	Chronic blockage of nostrils					
	Allergies – please describe:					

9.	Anxiety		
	Depression		
	ADHD		
	Alcohol dependence		
	Other psychiatric or psychological disease		
10.	Fibromyalgia / “ME”		
	Osteoarthritis		
	Rheumatoid arthritis		
	Other musculoskeletal disorder		

If you have arthritis, please state which joint(s) are affected:

	neck	Shoulders	elbows	Wrists	Hands	Spine	Hips	Knees	Ankles	Feet
(R)										
(L)										

11.	Have you had tonsillectomy?	No	Yes
12.	Have you been diagnosed with iron deficiency anaemia?	No	Yes
13.	Are you a strict vegetarian/vegan?	No	Yes
14.	If you are a woman, are you pregnant?	No	Yes
15.	If you are a woman, do you get heavy periods?	No	Yes – please give details below:
16.	Are you a blood donor?	No	Yes

Please list any other medical, surgical or psychiatric problem below:

Is there a history of any of the following conditions in your family? YES/NO

Your relationship ➔			
Sleep condition ➔			
Sleep Apnoea			
Restless Legs Syndrome			
Insomnia			
Sleep Terrors			
Sleepwalking			
Sleep related Epilepsy			
Other sleep problem			

	SECTION VIII: DO YOU TAKE ANY MEDICATIONS?	Yes	NO
	IF YES, PLEASE LIST THEM BELOW		
	Name of prescribed medication	**Dosage**	**Frequency**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
	IF you take any **'OVER THE COUNTER'** Medications, please list them below:		
1			
2			
3			
4			
5			

	Are you" allergic" to any drugs? YES - NO If YES, please give details below:		
	Name of Drug	**What symptoms do you get?**	**Who made the diagnosis of drug allergy?**

SECTION IX: SOCIAL HISTORY

What is your educational level?											
What is your home situation?											
Marital status	Single		Married		Divorced		Widowed		Widower		
Who shares your home?	Live alone		Partner		Parents		Children		Other:		

Do you smoke tobacco?		**Never smoked**	**Ex-smoker**	**Current smoker**
Type of tobacco	Amount	Year started	Year stopped	

Do you drink beverages containing CAFFEINE?	Yes / No					
If you do, what do you drink?	Coffee	Tea	Cola	Chocolate	Cocoa	Other
How many cups do you drink **daily**?						

Do you drink ALCOHOLIC beverages?	Yes / No
How much alcohol do you consume **in a week**?	
Do you use RECREATIONAL DRUGS?	Yes / No

Any STRESSFUL events in recent times?		No	If **Yes** – what does it relate to?		
Family	Personal	Work	Health	Environment	Other

DO YOU DRIVE?	Yes / No
What is your average annual mileage?	

Have you had any road traffic accidents in the last two years? Yes / No

If you had an accident:

What year/month did it occur?		Did your vehicle run off the road?	Yes / No
What time of the day / night did it occur?		Was the police involved?	Yes / No
Did you run in to the back of another vehicle?	Yes/ No	Was the vehicle a write off?	Yes / No

ABOUT YOUR WORK

In work [ ]	Not in work [ ]	Retired [ ]	Home maker [ ]	Student [ ]

If in work, what is your occupation?

If retired, what was your occupation?

Please describe the type of work you do/did:

Are you a professional driver?			Yes	No	
Do you drive a vehicle as part of voluntary work?			Yes	No	
If Yes, is it **(please circle)**	Taxi	Bus	HGV	Train	other
Do you operate heavy machinery?		**Yes**	**No**		

Have you had any accidents at your work place? If so, please describe:	Yes / No

Please describe the circumstances of the accident:

SECTION X: EPWORTH SLEEPINESS SCALE

Based on your experience in the **LAST MONTH** please rate **HOW LIKELY YOU ARE TO SLEEP** in the following situations.

We are **not asking you to rate how tired** you would be, **but how likely you would be to doze off.**

If you have not been in the following situations recently, think about how you would have been affected.

Circle the most appropriate number for each situation.

	Situations	Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
1.	Sitting and reading	0	1	2	3
2.	Watching TV	0	1	2	3
3.	Sitting Inactive in a Public Place	0	1	2	3
4.	As a passenger in a car for an hour	0	1	2	3
5.	Lying down to rest in the afternoon	0	1	2	3
6.	Sitting and talking to someone	0	1	2	3
7.	Sitting quietly after lunch without alcohol	0	1	2	3
8.	In a car while stopped in traffic for a few minutes.	0	1	2	3
	TOTAL				

FATIGUE SEVERITY SCALE

Read each statement and mark a number from 1-7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

A low value (e.g. 1) indicates strong disagreement with the statement, whereas a high value (e.g. 7) indicates strong agreement. It is important you circle a number (1 to 7) for every question.

		Disagree						**Agree**
1.	My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2.	Exercise brings on my fatigue.	1	2	3	4	5	6	7
3.	I am easily fatigued.	1	2	3	4	5	6	7
4.	Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5.	Fatigue causes frequent problem for me.	1	2	3	4	5	6	7
6.	My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7.	Fatigue interferes with carrying of certain duties and responsibilities.	1	2	3	4	5	6	7
8.	Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9.	Fatigue interferes with my work, family or social life.	1	2	3	4	5	6	7
	TOTAL =							**/63**

If you have symptoms of Insomnia (Question 14 on page 2), please complete this Insomnia Severity Index (ISI)

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**.

For the first three questions, please rate the **SEVERITY** of your sleep difficulties.

1. Difficulty falling asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

2. Difficulty staying asleep:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

3. Problem waking up too early in the morning:

None	Mild	Moderate	Severe	Very Severe
0	1	2	3	4

4. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood)?

Not at all Interfering	A little Interfering	Somewhat Interfering	Very Interfering	Extremely Interfering
0	1	2	3	4

6. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	A little Noticeable	Somewhat Noticeable	Very Noticeable	Extremely Noticeable
0	1	2	3	4

7. How **WORRIED**/distressed are you about your current sleep problem?

Not at all	A little	Somewhat	Very	Extremely
0	1	2	3	4

If you have answered 'YES' to Questions 6 (page 1) and/or Question 12 (page 2) you may have a sleep disorder known as 'Restless Legs Syndrome'. Please give us additional information by completing this page and next.

If you have uncomfortable feelings or sensations in your legs/ arms, what type of sensations do you get?
Please tick mark all that apply.

Creepy-crawly sensations		Grabbing sensation	
Pain		Electric current like sensations	
Throbbing sensation		Shock like feeling	
Burning sensation		Worms moving under the skin	
Tight feeling		The sensation is difficult to describe	

Other sensation (please describe):

When/at what age did you start getting these symptoms?

How did the condition progress?

Do any of your family members have such symptoms?

Now, Please complete the following questionnaire:

1. **In the past week,** overall, how would you rate the RLS discomfort in your legs or arms?

Very Severe	Severe	Moderate	Mild	None
4	**3**	**2**	**1**	**0**

2. **In the past week,** overall, how would you rate the need to move around because of your RLS symptoms?

Very Severe	Severe	Moderate	Mild	None
4	**3**	**2**	**1**	**0**

3. **In the past week,** overall, how much relief of your RLS arm or leg discomfort did you get from moving around?

No relief	Mild relief	Moderate relief	Either complete or almost complete relief	No RLS symptoms to be relieved
4	**3**	**2**	**1**	**0**

4. **In the past week**, how severe was your sleep disturbance due to your RLS symptoms?

Very Severe	Severe	Moderate	Mild	None
4	**3**	**2**	**1**	**0**

5.	**In the past week,** how severe was your tiredness or sleepiness during the day due to your RLS symptoms?				
	Very Severe	Severe	Moderate	Mild	None
	4	**3**	**2**	**1**	**0**
6.	**In the past week,** how severe was your RLS as a whole?				
	Very Severe	Severe	Moderate	Mild	None
	4	**3**	**2**	**1**	**0**
7	**In the past week,** how often did you get RLS symptoms?				
	Very Often (this means 6 to 7 days a week)	Often (this means 4 to 5 days per week)	Sometimes (this means 2 to 3 days per week)	Mild Occasionally (this means 1 day per week)	None
	4	**3**	**2**	**1**	**0**
8	**In the past week,** when you had RLS symptoms, how severe were they on average?				
	Very Severe	Severe	Moderate	Mild	None
	Very severe (this means 8hrs or more per 24hr day)	(this means 3 to 8hrs per 24hr day)	Moderate (this means 1 to 3hrs per 24hr day)	Mild (this means less than 1 hour per 24hr day)	
	4	**3**	**2**	**1**	**0**
9.	**In the past week,** overall, how severe was the impact of your RLS symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, school or work life				
	Very Severe	Severe	Moderate	Mild	None
	4	**3**	**2**	**1**	**0**
10.	**In the past week,** how severe was your mood disturbance due to your RLS symptoms – for example angry, depressed, sad, anxious or irritable?				
	Very Severe	Severe	Moderate	Mild	None
	4	**3**	**2**	**1**	**0**
	TOTAL SCORE = /40				

	Please tell us	
	Your height:	
	Your weight	
	Your ‘collar size’ (neck circumference)	
	Your blood pressure (if you know it)	
	Please add any other additional information you would like us to have:	

SECTION XI: QUESTIONS FOR PARTNER, FAMILY MEMBER, OR CLOSE ASSOCIATE

Do you have a partner, close family member or close associate who would be able to comment on your sleep and related issues?

If Yes, ask him/her to complete this section	**If NO, STOP here**

What is your relationship with the patient?	Spouse	Boyfriend/girlfriend	Parent	Associate
Do you live in the **same house?**	No	Yes		
Do you sleep in the **same room**?	No	Yes		
Do you share the **same bed?**	No	Yes		

	If you are the spouse/partner and you do not sleep in the same room/bed, is it because of his/her sleep behaviour (such as snoring loudly, acting out dreams etc)?	No	Yes
1 a	**Does the patient snore?**	No	Yes
	If yes, is the snoring loud?	No	Yes
	Does the snoring disturb others?	No	Yes
	Has the patient ever snorted or choked him/herself awake?	No	Yes
b	Does the patient ever seem to stop breathing during sleep?	No	Yes
	If yes is the patient currently being treated for this (e.g., CPAP)?	No	Yes
2	Does the patient complain of restless, nervous, tingly or creepy-crawly feeling in his/her legs that disrupts his/her ability to fall or stay asleep?	No	Yes
	If Yes, does the patient tell you that these leg sensations decrease when she/he moves their legs or walks around?	No	Yes
	When do these sensations seem to be worst — **Before 6pm:**		**After 6pm:**
3	Do the patient's legs repeatedly jerk or twitch during sleep (not just when falling asleep)?	No	Yes
4	Has the patient ever walked round the bedroom or house while asleep?	No	Yes
5	Does the patient ever have leg cramps at night (with intense pain in certain muscles in the leg)?	No	Yes
6	Rate the patient's general alertness for the past three weeks on a scale of 0-10		

Sleep all day	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Fully & normally awake**

7.	**Have you ever seen the patient appear to act out his/her dreams while sleeping (punched or flailed arms in the air, shouted or screamed)**	**No**		**Yes**
a	**If yes**, how many months or years has this been going on?	**Years:**		**Months:**
b	Has the patient ever been injured from these behaviours (bruises, broken bones)?	No	Yes	
c	Has a bed partner ever been injured from these behaviours (bruises, broken bones)?	No	Yes	No bed partner
d	Has the patient told you about dreams of being chased, attacked or that involve defending himself/herself?	No	Yes	Never told you about dreams
e	If the patient woke up and told you about a dream, did the details of the dream match the movements made while sleeping?	No	Yes	Never told you about dreams

8.	**To what extent has the patient's sleep problems affected his/her:**					
	Alertness and ability to stay awake.	Not at all	A little	Somewhat	Much	Very much
	Attention and concentration.	Not at all	A little	Somewhat	Much	Very much
	Memory.	Not at all	A little	Somewhat	Much	Very much
	Mood – anxious/depressed.	Not at all	A little	Somewhat	Much	Very much
	Behaviour – such as becoming more irritable, snappy etc..	Not at all	A little	Somewhat	Much	Very much
	Energy and productivity.	Not at all	A little	Somewhat	Much	Very much
9.	**To what extent has the patient's sleep problems affected your own sleep?**	Not at all	A little	Somewhat	Much	Very much

EPWORTH SLEEPINESS SCALE

To be completed by - Spouse/Partner/close Family Member or Close Associate, based on your observation of the patient in the last month.

We are not asking you to **rate how tired** the patient would be in these situations but how likely he/she would be to **actually doze off.** If he/she has not been in the following situations recently, think about how he/she would have been affected. Circle the most appropriate number for each situation.

		Would Never Doze	**Slight Chance of Dozing**	**Moderate Chance of Dozing**	**High Chance of Dozing**
1.	Sitting and reading	0	1	2	3
2.	Watching TV	0	1	2	3
3.	Sitting Inactive in a public place	0	1	2	3
4.	As a passenger in a car for an hour	0	1	2	3
5.	Lying down to rest in the afternoon	0	1	2	3
6.	Sitting and talking to someone	0	1	2	3
7.	Sitting quietly after lunch without alcohol	0	1	2	3
8.	In a car while stopped in traffic for a few minutes	0	1	2	3
	TOTAL				