1. Have you had any pregnancies since your last sleep study? _____ Yes _____ No

If yes, please indicate how many and in what year(s):

_____ #Pregnancies _____ Year(s)

2. Have you had surgery that caused your menstrual periods to stop permanently? _____ Yes _____ No

If yes, please provide the following information:

a. Indicate the date of surgery: _____ Month/Year

b. Identify the kind of surgery (check one):

_____ Hysterectomy, uterus and both ovaries removed.

_____ Hysterectomy, uterus and only one ovary removed.

_____ Hysterectomy, uterus removed, no ovaries removed.

_____ One ovary removed, uterus and one ovary remain.

_____ Both ovaries removed, uterus remains.

_____ Unsure: _____

3. Please indicate which category listed below best describes your menstrual cycle (check one).

a. _____ I have fairly regular menstrual periods. Enter the onset and ending date of your most recent cycle: _____ Month/Day/Year Onset _____ Month/Day/Year End.

b. _____ My menstrual periods are irregular. Enter the onset and ending date of your most recent cycle: _____ Month/Day/Year Onset _____ Month/Day/Year End.

Have you always had irregular periods? _____ Yes _____ No If no, when did your irregular periods start? _____ Month/Year OR _____ Age.

c. _____ I have no periods at all/menopause. Enter the date of your very last period or indicate how old you were when you had your last period: _____ Month/Year OR _____ Age.

4. **During the past year**, have you experienced any episodes of unusual sweating? _____ Yes _____ No

5. **During the past year**, have you noticed any episodes of a variation in your heart beat or any periods of a rapid heart be
_____ No

6. **During the past year**, has dryness caused you to experience painful intercourse?
_____ Yes _____ No _____ Does not apply

7. Has your menstrual cycle changed **over the past year**? _____ Yes _____ No _____ Does not apply

If yes, please indicate what they were like in the past and what they are like now by checking one item in each column for each
following categories:

	Past	Now

a. Time between periods:

Less than 25 days	____	____
25 to 30 days	____	____
31 to 35 days	____	____
More than 35 days	____	____
Irregular	____	____

b. Flow:

Light	____	____
Moderate	____	____
Heavy	____	____
Irregular	____	____

c. How long your periods last:

3 days or less	____	____
4 to 6 days	____	____
7 to 10 days	____	____
More than 10 days	____	____
Irregular	____	____

d. Please describe any other changes: _____

_____

_____

8. Has your sleep changed over the past year? _____ Yes _____ No

If yes, please indicate how your sleep has changed (check all that apply):

a. Sleep disturbed by:

_____ Hot flush/flashes.

_____ Recent surgery, illness, or injury.

_____ Depression, stress, or emotional upset.

_____ Need to go to the bathroom.

_____ Other. Please describe: _____

b. Sleep habits changed:

_____ Get more sleep.

_____ Get less sleep.

_____ Other. Please describe: _____

c. Sleep problems:

_____ Insomnia.

_____ Nightmares/bad dreams.

_____ Excessive sleeping (seem to be sleeping too much).

_____ Sleep is not refreshing.

_____ Other. Please describe: _____

d. Other changes in sleep:

_____ Please describe: _____

9. Do you or have you ever taken birth control pills? _____ Yes _____ No

If yes, please answer the following questions:

a. When did you begin taking them? _____ Month/Year OR _____ Age

b. Are you currently taking them? _____ Yes _____ No

c. If no, how long did you take them? _____ # of months OR _____ # of years

d. Please provide the brand or generic name of the birth control pill(s) you have taken.

_____

10. Have you ever taken supplemental hormones for menopause? _____ Yes _____ No

If yes, please answer the following questions:

a. When did you begin taking them? _____ Month/Year OR _____ Age

b. Are you currently taking them? _____ Yes _____ No

c. If no, how long did you take them? _____ # of months OR _____ # of years

d. Please provide the brand or generic name of the hormone(s) you have taken.

_____

11. Do you ever have hot flushes/flashes (a sensation of heat, often beginning in the torso or neck and spreading upward to the neck and face, or down to the shoulders and chest)? ____ Yes ____ No

a. If yes, when did you begin having them? _____ Month/Year OR _____ Age

b. Are they associated with any specific activity? ____ Yes ____ No

If yes, please indicate which activities are involved (check all that apply):

_____ Sleeping

_____ Stressful situations

_____ Eating

_____ Cold to warm temperature changes

_____ Alcohol consumption

_____ Working

_____ Recreation

_____ Relaxation

_____ Other/Please describe: _____