# BECK'S DEPRESSION INVENTORY

**Instructions:** Please circle the number by the response for each question that best describes how you have felt during the past seven (7) days. Please do not omit any questions. Make sure you check one answer for each question. If more than one answer applies to how you have been feeling, check the higher number. If in doubt, make your best guess.

1. 0 - I do not feel sad.
   1 - I feel sad.
   2 - I am sad all the time and I can't snap out of it.
   3 - I am so sad or unhappy that I can't stand it.

2. 0 - I am not particularly discouraged about the future.
   1 - I feel discouraged about the future.
   2 - I feel I have nothing to look forward to.
   3 - I feel that the future is hopeless and that things cannot improve.

3. 0 - I do not feel like a failure.
   1 - I feel I have failed more than the average person.
   2 - As I look back on my life, all I can see is a lot of failures.
   3 - I feel I am a complete failure as a person.

4. 0 - I get as much satisfaction out of things as I used to.
   1 - I don't enjoy things the way I used to.
   2 - I don't get real satisfaction out of anything anymore.
   3 - I am dissatisfied or bored with everything.

5. 0 - I don't feel particularly guilty.
   1 - I feel guilty a good part of the time.
   2 - I feel quite guilty most of the time.
   3 - I feel guilty all of the time.

6. 0 - I don't feel I am being punished.
   1 - I feel I may be punished.
   2 - I expect to be punished.
   3 - I hate myself.

7. 0 - I don't feel disappointed in myself.
   1 - I am disappointed in myself.
   2 - I am disgusted with myself.
   3 - I hate myself.

8. 0 - I don't feel I am any worse than anybody else.
   1 - I am critical of myself for my weaknesses or mistakes.
   2 - I blame myself all the time for my faults.
   3 - I blame myself for everything bad that happens.

9. 0 - I don't have any thoughts of killing myself.
   1 - I have thoughts of killing myself, but I would not carry them out.
   2 - I would like to kill myself.
   3 - I would kill myself if I had the chance.

10. 0 - I don't cry any more than usual.
    1 - I cry more now than I used to.
    2 - I cry all the time now.
    3 - I used to be able to cry, but now I can't cry even though I want to.

**Turn The Page Over**

11. 0 - I am no more irritated by things than I ever am.
1 - I am slightly more irritated now than usual.
2 - I am quite annoyed or irritated a good deal of the time.
3 - I feel irritated all the time now.

12. 0 - I have not lost interest in other people.
1 - I am less interested in other people than I used to be.
2 - I have lost most of my interest in other people.
3 - I have lost all of my interest in other people.

13. 0 - I make decisions about as well as I ever could.
1 - I put off making decisions more than I used to.
2 - I have greater difficulty in making decisions than before.
3 - I can't make decisions at all anymore.

14. 0 - I don't feel that I look any worse than I used to.
1 - I am worried that I am looking old or unattractive.
2 - I feel that there are permanent changes in my appearance that make me look unattractive.
3 - I believe that I look ugly.

15. 0 - I can work about as well as before.
1 - It takes an extra effort to get started at doing something.
2 - I have to push myself very hard to do anything.
3 - I can't do any work at all.

16. 0 - I can sleep as well as usual.
1 - I don't sleep as well as I used to.
2 - I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 - I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 - I don't get more tired than usual.
1 - I get tired more easily than I used to.
2 - I get tired from doing almost anything.
3 - I am too tired to do anything.

18. 0 - My appetite is no worse than usual.
1 - My appetite is not as good as it used to be.
2 - My appetite is much worse now.
3 - I have no appetite at all anymore.

19. 0 - I haven't lost or gained much weight, if any, lately.
1 - I have lost or gained more than five pounds.
2 - I have lost or gained more than ten pounds.
3 - I have lost or gained more that fifteen pounds.

20. 0 - I am no more worried about my health than usual.
1 - I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 - I am very worried about physical problems and it's hard to think of much else.
3 - I am so worried about my physical problems that I cannot think of anything else.

21. 0 - I have not noticed any recent change in my interest in sex.
1 - I am less interested in sex than I used to be.
2 - I am much less interested in sex now.
3 - I have lost interest in sex completely.

**Name**_____**Date**_____**Total**_____

1-10 Normal; 11-16 Mild;17+ Clinical Depression:17-20 Borderline, 21-30 Moderate, 31-40 Severe, 41+ Extreme

# THE LUNG CENTER

Sleep Disorders Specialists of Manatee

• Robert A. Fasoli, M.D. • Michael D. Seeman, M.D.
• Floyd W. Wells, M.D. • Janine M. Mylett, M.D. • Michael W. Burke, M.D.


## INITIAL SLEEP EVALUATION FORM:

**Today's Date:** _____

**First Name:** _____ **Last Name:** _____
**Age:** _____ **Phone number :**
**Sex:** ☐ Male ☐ Female
**Race:** ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____
**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow
**Education:** ☐ High school grad. ☐ College grad.
**Occupation:** _____ ☐ Retired ☐ Disabled
**Your usual work schedule:** _____

**Referring Physician's Name:** _____
**Full Address:** _____ **City/State/Zip:** _____
**Your Physician's Phone# :(** ___ **)** _____

**Your current MAIN SLEEP COMPLAINTS are:**

☐ Feeling sleepy most of the time ☐ Snoring Loud
☐ Difficulty falling sleep ☐ Difficulty maintaining sleep
☐ Other: _____
**How long has this problem bothered you?** _____ **months/years**

**PREVIOUS SLEEP EVALUATION**

**Name of Hospital/Sleep Center:** _____ **Location:** _____
**Approximate date of sleep study:** _____
**Diagnosis:** _____
**Previous Treatments:** _____

**Please mark all your MEDICAL CONDITIONS:**

☐ High Blood Pressure ☐ Diabetes/ or High Blood Sugar
☐ High Cholesterol ☐ Thyroid diseases
☐ Heart failure ☐ Previous heart attack
☐ Chest pains or Angina
☐ Cardiac Arrhythmia : If known What Type? _____
☐ Stroke
☐ Persistent Headaches ☐ Seizure/epilepsy
☐ Asthma ☐ COPD (chronic bronchitis or emphysema)
☐ Reflux ☐ Arthritis (joint pain)
☐ Sinus trouble ☐ Persistent congestion of nose
☐ Cancer type & location_____ When diagnosed: _____
☐ Depression ☐ Anxiety disorder
☐ Schizophrenia ☐ Bipolar disorder
**Please list your all other medical problems:** _____
_____



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**Sleep Related History**

*Please rate yourself by circling the number 1-7 that best describes the degree or frequency that you are bothered by a particular complaint or problem.*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| None | Very slight | Slightly | Moderate | Major | Great | Very great |
| Never | Rare | Seldom | Occasionally | Often | Very often | Always |

## Do you have or How often do you experience the followings?

1 2 3 4 5 6 7 **Loud snoring**
1 2 3 4 5 6 7 **Your bed partner sleep separately due to your snoring**
1 2 3 4 5 6 7 **Your bed partner note that you stop breathing**
1 2 3 4 5 6 7 **Waking up with breakthrough chocking/gasping**
1 2 3 4 5 6 7 **Dryness of throat on awakening**
1 2 3 4 5 6 7 **Headaches on awakening**

1 2 3 4 5 6 7 **Feeling unrested** even after adequate hours of sleep?
1 2 3 4 5 6 7 **Falling asleep while driving?**

1 2 3 4 5 6 7 **Paralysis (unable to move)** when just falling asleep or waking up
1 2 3 4 5 6 7 **Hallucinations (people, voices, or sounds)** in the room when just falling asleep or when awakening
1 2 3 4 5 6 7 **Sudden muscular weakness** with laughing, angry, or emotional situations
1 2 3 4 5 6 7 **Colorful** or **vivid dreams**

1 2 3 4 5 6 7 **Sleep walking**
1 2 3 4 5 6 7 **Unusual behaviors** during sleep:
Circle the type: **violent movement** **eating confusion** **screaming-out**
1 2 3 4 5 6 7 **Nightmare**
1 2 3 4 5 6 7 **Acting out to your dreams**
1 2 3 4 5 6 7 **Heartburn** or **stomach acid in the mouth**
1 2 3 4 5 6 7 **Grinding teeth while sleeping**
1 2 3 4 5 6 7 **Irresistible urge to move legs** in the evening /night
Circle the type: **aching** **crawling** **creepy** **restlessness**
1 2 3 4 5 6 7 **Legs kicking or twitch during sleep**

1 2 3 4 5 6 7 **Problem with attention** or **concentration**
1 2 3 4 5 6 7 **Problem with memory**
1 2 3 4 5 6 7 **Feeling of depression**
1 2 3 4 5 6 7 **Feeling of anxiety**
1 2 3 4 5 6 7 **Claustrophobia (fear of being in tight place)**
1 2 3 4 5 6 7 **Sexual dysfunction**

1 2 3 4 5 6 7 **Problem falling asleep**
1 2 3 4 5 6 7 **Racing thoughts at bedtime**
1 2 3 4 5 6 7 **Panic attack during sleep**



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Have you had **any change in weight over last 6months?**
**If yes did you:** ☐**Gain** ☐**Lost** **How much?** ____ **lb**
**Do you do any exercise?** ☐No ☐Yes->if yes what kind? _____
How often? ____ times per week for ____hours. What time usually? _____am/pm

**Epworth Sleepiness Scale:**

*In contrast to just feeling tired, **how likely are you to doze off** or fall asleep in the following situations? 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:*

| 0 | 1 | 2 | 3 |
|---|---|---|---|
| **Never** | **Slight chance** | **Moderate chance** | **High chance** |

Sitting & reading _____
Watching TV _____
Sitting inactive in a public place (i.e. theatre) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting & talking to someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopping for a few minutes in traffic _____
total score: _____

*(normal: 1-7, mild: 8-11, moderate: 12-16, severe: 17-20, very severe:21-24)*

**Sleep Habits:**

What time you usually **go to bed? Weekdays?**____pm/am **Weekends?**___pm/am
How long does it take for you to **fall asleep?** _____minutes
What time do you usually **get up? Weekdays?**_____pm/am **Weekends?**___ _pm/am
How many times do you **wake up** while sleeping? ____times
What is the **reason** usually you **wake up?** ☐Unknown ☐other: _____
Do you take **naps during day?** ☐No ☐ If yes **how often?**____times/day.
How **many minutes**? ____ min. **What time**? _____

Do you have a **TV/Radio in your bedroom?** ☐Yes ☐No
Do you **fall asleep easier in other places than your bed**? ☐ No ☐Yes, if so
Where ?_____
Do you have any **complaints related to your bedroom environment**? ☐No ☐Yes
Please explain: _____

**Social History:**

**Have you been a smoker?** ☐No ☐Yes _____ **packs per day** for _____ **years**
**Have you quit smoking?** ☐No ☐Yes How many years ago? _____
**Do you drink alcohol?** ☐No ☐Yes ___ drink per weeks
**Do you use any illicit drug?** ☐No ☐Yes->if yes what kind ? _____
**Coffee:** _____ cups per day. What time is your last drink prior to sleep? ___am/pm
**Tea or Ice tea:** _____ cups per day. What time is your last drink prior to sleep? ___am/pm
**Caffeinated soda:** _____ cans per day. What time is your last drink prior to sleep? ___am/pm



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**Other Medical History & Review of Systems:**

| | | | | |
|---|---|---|---|---|
| **Do you have seasonal allergies?** | ☐ **No** | ☐ **Infrequent** | ☐ **Continuous** | |
| **Do you have sinusitis?** | ☐ **No** | ☐ **Infrequent** | ☐ **Continuous** | |
| **Do you have nasal congestion?** | ☐ **No** | ☐ **Infrequent** | ☐ **Continuous** | |
| **Have you had any history of broken nose?** | ☐ **No** | ☐ **Yes** | | |
| **Have any had any serious head injury?** | ☐ **No** | ☐ **Yes** | | |
| **Have you ever had seizures?** | ☐ **No** | ☐ **active** | ☐ **controlled on medication** | ☐ **Past)** |

Do you have any **family history of sleep disorder?** ☐No ☐if yes what kind?
Obstructive sleep apnea Narcolepsy Restless leg Syndrome (RLS) or PLM
Other: _____
Do you have any **known allergies to any medication?** ☐No ☐ If yes: _____

**Surgical History**

**Did you have your tonsils removed?** ☐**No** ☐**Yes, if so what Age:** _____
**Do you have dentures?** ☐**No** ☐**upper teeth** ☐**Lower teeth** ☐**both upper & lower**
**Other:** _____

**MEDICATIONS:**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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**STOP! THE REST TO BE FILLED BY THE SLEEP CLINIC STAFF**



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