Appendix: Sleep Disorders Questionnaire

Welcome!
Please answer our questions and tell us how you have felt recently and what complaints you have had. For ratings such as: "severity", "frequency", "duration", please indicate how it has been approximately on average over the last 7 days

Medications

Have you taken any medications or food supplements in the last 30 days or for the time since the last monitoring? (Also infusions, TCM medications, homeopathic remedies and others.)

◯ Yes ◯ No

If Yes

◯ Antiasthmatics ◯ Antibiotics (except against Helicobacter pylori) ◯ Antiallergics ◯ Antiallergics

◯ Antifungals (e.g. Nystatin) ◯ Cholesterol-lowering drugs (e.g. Simvastatin) ◯ Anticoagulants (e.g. Marcumar, Heparin, ASS)

◯ Skin care products/ointments (prescription) ◯ Heart medication/ blood pressure medication (e.g. Ramipril, ASS)

◯ Homeopathics (e.g. (e.g. Dulcolax, Iberogast) ◯ Psychopharmaceuticals (except for insomnia) ◯ Sleeping pills

◯ Painkillers ◯ Metabolism regulators/ hormones (e.g. thyroid medication, birth control pills) ◯ Vitamins, minerals

◯ TCM medication (e.g. Coloca Form, Cardio Form) ◯ Probiotics (e.g. Eugalan, Omni Biotic Stress)

◯ If yes, please list all medications and describe since when and how often you have taken/take them and state the amounts and times of intake (e.g. morning, noon, evening). (E.g. Ace 100 mg, 1x morning, since 2002)

_____

_____

_____

Do you have any current complaints or illnesses?

Do you have any acute complaints?

◯ Yes ◯ No

If yes, please tick

◯ headache/migraine ◯ fever diarrhoea/constipation ◯ gastrointestinal ◯ cramps ◯ skin rash ◯ flu-like infection

◯ bladder infection ◯ allergic reactions ◯ fatigue

◯ other: _____

Please specify here:

_____

_____

_____

Sleep

Please give us an impression of how you rate your condition for the last 7 days by ticking the scale:as rather good (1) or as rather bad (10)?

How would you rate your sleep during the last 7 nights?

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

How many minutes do you usually need to fall asleep?

◯ 1-20 min ◯ 20-40 min ◯ 40-60 min ◯ 60-90 min ◯ more than 90 min

On average, how often do you wake up during the night?

◯ 0x ◯ 1x ◯ 2x ◯ 3x ◯ 4x ◯ Very often

Were there any special circumstances that caused you to wake up (e.g. party, noise, sadness, stress, anger)?

◯ Yes ◯ No ◯ I did not wake up.

If yes, which ones?

_____

_____

_____

How many hours did you sleep on average per night in the last 7 days?

◯ 7 and more ◯ 5-6 ◯ 4 and less

In the last 30 days or in the time since the last monitoring, have you taken sleeping pills to help you fall asleep or sleep through the night, or medicines to treat infections and pathogenic yeasts? (e.g. antibiotics, valerian, teas that are available over-the-counter or by prescription?)

◯ Yes ◯ No

If yes, which ones?

◯ TCM medicines (e.g. teas) ◯ Antibiotics ◯ Antifungals to treat pathogenic yeasts (e.g. Nystatin, Ampho Moronal)

◯ O Probiotics (z. B. Omni Biotic Stress, Eugalan) ◯ other _____

If yes, please list all medications and describe since when and how often you have been taking/taking them and state the amounts and times (e.g. morning,noon, evening).

_____

_____

_____

Have you slept during the day (nap) in the last 7 days?

◯ Yes ◯ No

How many hours on average have you slept during the day?

◯ 0 ◯ 0,5 ◯ 1 ◯ 2 ◯ 3

Do you sweat a lot?

◯ Yes ◯ No

Do you tend to be too warm/hot during the day?

◯ Yes ◯ No

Do you often feel too cold during the day or do you often feel cold or cold for no reason?

◯ Yes ◯ No

General condition and performance

Please give us an impression by ticking the scales how you assess your condition for the last 7 days: as rather good (1) or as rather bad (10)?

Overall condition/quality of life

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Physical general condition

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Occupational/family performance

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Physical fitness

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Capacity to concentrate

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Psychical/mental condition

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Digestion

Did you suffer from gastrointestinal complaints in the last 7 days?

◯ Yes ◯ No

Please give us an impression by ticking the scales how you rate your condition for the last 7 days,rather good, little, hardly (1) or rather bad, strongly, frequently (10)? Questions about bowel movements follow!

General digestion

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Feeling full

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Bloating

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Stomach cramps and pain

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Sodburn

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Did you usually have a bowel movement every day in the last 7 days?

◯ Yes ◯ No

If you usually have a bowel movement every day, how often?

◯ 1x ◯ 2x ◯ 3x ◯ 4x ◯ 5x and more

If you did not usually have a bowel movement every day, how often? every one to two days

◯ every two to three days ◯ every three to four days ◯ every four to five days ◯ intermittent and very irregular

Did you have diarrhoea/mushy, soft stools in the last 7 days?

◯ Yes ◯ No

Did you have constipation in the last 7 days?

◯ Yes ◯ No

Did you have to urinate frequently during the day in the last 7 days?

◯ Yes ◯ No

Did you have any discomfort when urinating in the last 7 days?

◯ Yes ◯ No

Did you suffer from nocturia (frequent urination at night) in the last 7 days?

◯ Yes ◯ No

If you usually have a bowel movement every day, how often?

◯ 1x ◯ 2x ◯ 3x ◯ 4x and more

Sports and exercise

Did you do any sports in the last 7 days?

◯ Yes ◯ No

If yes, how often did you do any sports?

◯ 1x weekly ◯ 2x weekly ◯ 3-5x weekly ◯ every day

If yes, daily for how long?

◯ < 30-60 min ◯ 60-90 min ◯ > 90 min

Did you go for regular walks?

◯ Yes ◯ No

If yes, for how long?

◯ < 30 min ◯ 30-60 min ◯ 60-90 min

> 90 minIf yes, when?

◯ morning ◯ noon ◯ evening

If yes, what kind of sport do you do?

Eating and drinking

How much drink you daily?

◯ 0.5 litres ◯ 1 litres ◯ 1.5 litres ◯ 2 litres ◯ 3 litres ◯ 5 litres

Do you regularly drink alcohol (outside medical use)?

◯ Yes ◯ No

If yes, what and how much?

Have you eaten a balanced, sufficient and regular diet in the last 7 days or for the time since the last monitoring?

◯ Yes ◯ No

Skin, hair, nails

Did you notice any skin changes/itching in the last 7 days?

◯ Yes ◯ No

If yes, where?

◯ hairy head ◯ face ◯ neck ◯ chest ◯ hands ◯ feet ◯ belly ◯ genital area

◯ arms ◯ legs

If yes, please specify further if necessary:

Do you currently suffer from infections of the fingernails (e.g. nail fungus)?

◯ Yes ◯ No

Do you currently suffer from infections of the toenails (e.g. nail fungus)?

◯ Yes ◯ No

Do you currently suffer from infections of the feet (e.g. athlete's foot)?

◯ Yes ◯ No

Does your skin currently peel on your toes or between your toes?

◯ Yes ◯ No

Quality of life

How much have your skin conditions, digestion or sleep problems prevented you from shopping or doing housework or gardening in the past 7 days?

◯ very ◯ fairly ◯ somewhat ◯ not at all

How much have your skin conditions, digestion or sleep problems affected your activities with other people or your leisure time in the past 7 days?

◯ very ◯ fairly ◯ somewhat ◯ not at all

During the past 7 days, have your skin conditions, digestion or sleeping problems prevented you from working or studying?

◯ Yes ◯ No

During the past 7 days, have your skin conditions, digestion or sleeping problems prevented you from working or studying?

◯ Yes ◯ No

If yes, how often have you been off sick in the past 7 days due to your condition?

◯ 1x ◯ 2x ◯ 3x or more

If No, how much of a problem have your skin conditions, digestion or sleeping problems been in the past 7 days for your work or study/training?

◯ very ◯ fairly ◯ somewhat ◯ not at all

Doctor visits

◯ How often did you have to see a doctor due to your illness in the last 7 days?

If yes, please specify further if necessary:

◯ 1x ◯ 2x ◯ 3x ◯ 4x ◯ 5x and more

If you want to look at your answers again, then scroll back if necessary. If you are finished, then scroll on to submit the medical history. Thank you for filling out your medical history!