Name: DOB: Date form completed:

Sleep Disorders Questionnaire

1. Who encouraged you to get a sleep disorders evaluation?
(e.g. spouse, friend, doctor (doctor's name), hospital experience, your own concerns)

_____

2. What do you hope to achieve from this consultation?

_____

_____

☐ I do not feel I have a sleep problem

3. What do you do during the hour before turning out the lights (circle)?
e.g. TV/streaming video, listen to music, reading, internet browsing, email, work

_____

4. What part of your home are you usually in during this pre-bedtime activity?

_____

5. Do you use marijuana (CBD, THC), nicotine, alcohol, other substances near bedtime?
☐ No ☐ Yes (list) _____

6. Do you currently use any **prescription** *or* **over-the-counter sleep aids**?
Current sleep aids: _____
How well are they working on a 1-10 scale, 1 = not at all, 10 = extremely helpful _____
Comments:_____

Past sleep aids tried: _____

7. What time do you usually **close your eyes and try to fall asleep?**
a. Weekdays/work or school days _____
b. Weekends/days off _____

8. How long does it usually take to initially fall asleep **after you first turn off lights & try to go to sleep**? (give a range) _____

9. How often do you wake up at night (range)? _____

10. Why do you wake up at night? ☐bathroom • ☐snoring • ☐trouble breathing
☐choking feeling • ☐acid reflux or heartburn • ☐anxiety/worry • ☐palpitations
☐leg pain/discomfort • ☐jumpy legs • ☐restless legs • ☐pain (where) _____
other (explain) _____

11. Do you frequently eat/snack when you wake up at night? ☐Yes ☐No

12. If you wake at night, is it often difficult to get back to sleep? ☐Yes (explain) ☐No

13. What time do you get up for **work or school** (if applicable)? _____
How much total sleep do you think you get most **work/school nights?** _____

14. What time do you get up on **weekends or non-work days**? _____
How much total sleep do you think you get most **weekend or days off?** _____

Name: DOB: Date form completed:

15. Do you use an **alarm clock or clock radio** to help you wake up?
☐ No/not often ☐ most or every day ☐ work/school days only

16. Most days I wake up feeling:
☐ Full of energy and wide awake
☐Somewhat rested, could probably use more sleep
☐ Still tired or sleepy

17. Do you take **naps** during the day?
a. ☐Never • ☐1-2x weekly • ☐3-4x weekly • ☐5-6x weekly • ☐everyday
b. How long do you usually nap?_____
c. Do you wake up from your naps rested/refreshed? ☐Yes • ☐No • ☐Somewhat

18. Do you **fall asleep unintentionally** during the day?
(e.g. work, meetings, school, reading, driving, TV etc)
☐Never • ☐Occasionally • ☐Most days
Examples: _____

19. Do you **frequently** get **sleepy or drowsy while driving**?
☐Yes • ☐No • ☐I do not drive

20. Do you often let someone else drive because of sleepiness or fatigue? ☐Yes • ☐No

21. Over past five years have you had any motor vehicle accidents or "near-misses" while driving due to sleepiness, drowsiness or fatigue? ☐Yes • ☐No
Details if yes: _____

22. Do you have difficulty with ☐**Short term memory** ☐**Focus/concentration**

23. When you try to relax in the evening or at bedtime, do you ever have **unpleasant, restless feelings in your legs, arms** or **body** (*other than muscle cramps*) that can be relieved by movement (e.g. stretching or massaging legs, pounding legs, walking)?
☐Never • ☐1-3 times per/month • ☐1-3x/week • ☐Most days
Describe the feeling:_____
How old were you when the unpleasant restless feelings started? _____

24. Have you been told or noticed that your arms/legs jump or twitch when you sleep?
☐Never • ☐Occasionally • ☐Most nights

25. Do you experience **muscle cramps in your legs at night**?
☐Never • ☐Occasionally • ☐Most nights

26. Are you a **restless sleeper**? ☐Yes • ☐No
(change positions a lot, toss and turn, wake up with bed sheets and blankets out of place)

27. What position(s) do you sleep in?

☐back • ☐left side • ☐right side • ☐stomach • ☐chair • ☐hospital-type bed

Name: DOB: Date form completed:

28. Do you **snore** loud enough to **wake yourself up or disturb others**?
☐Never • ☐Occasionally • ☐Most nights • ☐Only sleeping on my back

29. Have you been told that you **hold your breath** *or* **stop breathing while you sleep**? ☐Yes • ☐No Explain: _____

_____

30. Do you wake up with a **choking feeling** at night?
☐Never • ☐Occasionally • ☐Frequently

31. Do you wake up with **heartburn or acid reflux**?
☐Never • ☐Occasionally • ☐Frequently

32. Do you **wake up from sleep** feeling **short of breath** or **gasping for air**?
☐Never • ☐Occasionally • ☐Frequently

33. Do you frequently wake up with a **dry mouth**? ☐Yes • ☐No

34. Do you **wake up with a headache**?

☐Never • ☐1-3x/month • ☐1-3x/week • ☐Most days

35. Do you ☐**Grind** • ☐**Clench** • ☐**wake up w/ sore jaw** • ☐None of these

36. Do you or have you used a **Nite (Bite) Guard** to protect your teeth? ☐Yes • ☐No

37. Do you get up to **urinate at night**? ☐Yes • ☐No How often? _____

38. Do you tend to **sweat heavily at night**? ☐Never • ☐Occasionally • ☐Most nights

39. Have you ever woken up feeling like you were ***acting out a dream***, e.g. **kicking, punching, jumping out of bed in response to your dream**? ☐ Yes • ☐ No

40. Do you **sleepwalk** or **experience other unusual behaviors while sleeping**

in past five years? ☐Yes • ☐No
Provide details:_____

_____

41. Have you had a **seizure (convulsion, epilepsy) while sleeping** *in past five years*?
☐Yes • ☐No
If yes, describe what happened? _____

_____

42. Did you ever drive your car somewhere, then not remember driving there?
□Yes • □No

43. Do you ever **fall asleep suddenly during the day**, without feeling sleepy a few minutes earlier? □Never • □Occasionally • □Frequently

44. How often do you **dream at night**? □Never • □Occasionally • □Most nights

45. Do you have **nightmares/abnormal dreams**?
□Never • □Occasionally • □Most nights

46. Do you experience **dreams during daytime naps**? □Never • □Occasionally • □Often

47. Have you ever woken up feeling completely aware & alert, able to hear your surroundings, but unable to move your body? □Yes • □No

48. Have you ever felt like you:
a. started to dream before falling asleep □Yes • □No
b. were still experiencing a dream after you woke up □Yes • □No

49. Do you or have you ever experienced episodes of **muscle weakness, loss of muscle strength in face, neck, arms or legs when you laugh or are surprised**?
□Yes • □No
Describe what happens: _____
_____

50. Do you frequently travel across 2 or more time zones? □Yes • □No

51. Do you or those who know you consider you a
a. "**night owl**" □Yes • □No • □Somewhat
b. "**morning person**" □Yes • □No • □Somewhat

52. Do you worry or experience **anxiety about your sleep**?
□Never • □Occasionally • □Most nights

53. **<u>Over past few months</u>**, how often do you experience these issues
a. At bedtime, **thoughts race through my mind**
□Never • □Occasionally • □Most nights
b. At bedtime, **I worry about things**
□Never • □Occasionally • □Most nights
c. At bedtime, **I'm afraid of not being able to go to sleep**
□Never • □Occasionally • □Most nights
d. **After waking up at night**, **I'm afraid I will not get back to sleep**
□Never • □Occasionally • □Most nights
e. **I sleep better in unfamiliar places such as a hotel room**
□Never • □Occasionally • □Most nights

Name: DOB: Date form completed:

54.Insomnia

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
A. Difficulty falling asleep	☐ 0	☐1	☐ 2	☐ 3	☐ 4
B. Difficulty staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C. Problems waking up too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

D. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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

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

F. How **WORRIED/DISTRESSED** are you about your current sleep pattern?

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

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

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

55. Daytime sleepiness

How likely are you to doze or fall asleep in the situations described below, in contrast to just feeling 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

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing			
	Never	Slight	Moderate	High
Sitting and reading	☐ 0	☐1	☐ 2	☐ 3
Watching TV	☐ 0	☐1	☐ 2	☐ 3
Sitting, inactive in a public place (e.g. a theater or a meeting)	☐ 0	☐1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐1	☐ 2	☐ 3

Name: DOB: Date form completed:

56. Daily functioning

Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you generally have difficulty remembering things because you are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty watching a movie or video because you become sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
Has your mood been affected because are sleepy or tired?	☐ 1 Yes, extreme	☐2 Yes Moderate	☐ 3 Yes, a little	☐ 4 No
	Total score:			

Name: DOB: Date form completed:

57. <u>Over the past 2 weeks</u>, how often have you been bothered by any of the following?

	Not At all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying	☐	☐	☐	☐
c. Little interest or pleasure in doing things?	☐	☐	☐	☐
d. Feeling down, depressed or hopeless?	☐	☐	☐	☐

58. <u>Over the past month</u>, how much of a problem were the following conditions for you?

	None	Very mild	Moderate	Fairly bad	Severe
a. Nasal congestion or stuffiness	☐0	☐ 1	☐ 2	☐ 3	☐ 4
b. Nasal blockage or obstruction	☐0	☐ 1	☐ 2	☐ 3	☐ 4
c. Trouble breathing thru nose	☐0	☐ 1	☐ 2	☐ 3	☐ 4
d. Unable to get enough air thru my nose during exertion or exercise	☐0	☐ 1	☐ 2	☐ 3	☐ 4
e. Trouble sleeping	☐0	☐ 1	☐ 2	☐ 3	☐ 4

59. <u>Past testing and treatment for sleep problems</u>

☐ past evaluation with a sleep specialist; if so where/who with? _____

_____

☐ past sleep study at home; if so with what doctor or company? _____

☐ past sleep study overnight at a sleep testing facility; if so where? _____

_____

☐ past or current use of **CPAP or bilevel PAP** machine at home; if so describe experience

_____

What brand and model PAP machine are you using? _____

Please list serial number of your current PAP machine _____

What brand, model and size CPAP mask are you using? _____

☐ prior **diagnosis of sleep apnea**

☐ past **surgery for sleep apnea**

☐ past or current use of a **dental appliance to treat sleep apnea**

☐ **teeth grinding or clenching (bruxism)**

☐ **mouth guard for teeth grinding or clenching**

☐ past or current treatment for **restless legs syndrome** or **periodic limb movements**

☐ past or current treatment for **REM sleep behavior disorder** (acting out your dreams)

☐ past or current treatment for **excessive daytime sleepiness** or **narcolepsy**

☐ past or current **medication or cognitive behavioral therapy for insomnia** for **insomnia**

List treatments: _____

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60. Check any of these medical problems you have <u>currently or in the past</u>?

☐ Bipolar disorder
☐ major depression
☐ anxiety disorder
☐ obsessive-compulsive disorder
☐ post-traumatic stress disorder
☐ attention deficit disorder
☐ eating disorder
☐ schizophrenia
☐ alcohol abuse
☐ cocaine use
☐ methamphetamine use
☐ other drug abuse

_____

☐ chronic fatigue syndrome
☐ fibromyalgia
☐ frequent headaches
☐ migraines
☐ other long-term pain

_____

_____

☐ autoimmune disorder
(e.g. lupus, rheumatoid arthritis)

_____

☐ Underactive thyroid
☐ anemia
☐ iron-deficiency
☐ other blood diseases

_____

☐ Nose sinus allergies
☐ recurring sinus infections
☐ Asthma
☐ COPD/emphysema

☐ pulmonary hypertension
☐ pulmonary fibrosis
☐ other lung disease

_____

_____

☐ enlarged prostate
☐ bladder problems
☐ long-term kidney disease

☐ Parkinson's
☐ seizures/epilepsy
☐ dementia
☐ stroke
☐ TIA
☐ head injury with loss of consciousness
☐ peripheral neuropathy
☐ neuromuscular disease
☐ glaucoma
☐ optic neuropathy

☐ GERD/acid reflux
☐ irritable bowel (IBS)
☐ active liver disease
☐ Ulcerative colitis or Crohn's

☐ high blood pressure
☐ dizziness or faintness if standing up too quickly
☐ cholesterol or triglyceride problem
☐ diabetes
☐ atrial fibrillation/atrial flutter
☐ other heart rhythm problem

_____

☐ pacemaker
☐ implantable defibrillator
☐ heart ablation procedure
☐ heart attack
☐ coronary artery disease
☐ congestive heart failure
☐ coronary stent/angioplasty
☐ heart bypass surgery
☐ heart valve problems
☐ heart valve replaced
☐ blood clots in leg
☐ blood clots in lung

☐ TMJ problems/surgery
☐ dentures
☐ dental implants
☐ limited jaw opening
☐ underbite ☐ overbite
☐ tongue thrusting
☐ orthodontia, braces etc
☐ wisdom teeth removed

61. List any forms of **cancer/malignancy** you have or had in past + treatments:

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62. Check any of these **surgery/medical procedures** you have had & **what year**

☐ tonsils removed	☐ surgery for acid reflux	☐ lung surgery: describe
☐ nasal septum repaired	☐ gastric bypass	
☐ nasal turbinate reduced	☐ gastric sleeve	
☐ jaw surgery	☐ gastric lap band	
☐ tongue surgery		
☐ adenoids removed		☐ prostate surgery
☐ soft palate/uvula removed		
☐ sinus surgery		
		☐ hysterectomy
Other major surgery:		
		☐ ovaries removed

List all **prescription medications** you take including asthma inhalers, nasal sprays, topical medications and as needed medications (OR ATTACH A LIST)

Name of medicine	**Dose** (e.g. mg)	**How often do you take it?**

63. List all **over-the-counter medicine** you take, including vitamins, supplements, herbals

64. List any **medications** you are **allergic to, sensitive to** or **react badly to**:

Name of Medicine	**Reaction** (e.g. hives, swollen tongue, trouble breathing)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

65. Have you had **x-ray test where dye (contrast) was injected into your blood?**

☐Yes ☐No

If yes, describe any side effects or allergic reaction to the dye: _____

_____

66. Have you ever received **chemotherapy** ☐Yes ☐No **radiation therapy**? ☐Yes ☐No

Describe: _____

67. Home relationships:

a. ☐married/long-term relationship ☐never married ☐widowed
b. ☐separated ☐divorced
c. ☐my spouse/significant other sleeps in a separate bed or separate bedroom

68. Who lives at home with you? _____

69. Bed partner(s) or roommates?

☐ significant other/roommate sleeps in other room

☐ significant other/roommate sleeps in same room but not same bed

☐ significant other/roommate sleeps same bed

☐ children in same bed

☐ children in same room but not same bed

70. Where did you grow up? _____

How long have you lived locally? _____

71. What is your highest level of school attended? _____

72. Current employment/school status? (includes volunteer work)

☐self-employed ☐employed full-time ☐employed part-time
☐retired ☐full-time homemaker ☐on disability
☐full-time caretaker ☐full-time student ☐part-time student

73. What is your current or most recent occupation? _____

74. Long-term past occupations: _____

75. Military experience? _____

_____

76. Describe your diet: _____

77. Usual exercise: _____

78. Do you currently smoke: ☐vape or E-cigarettes ☐cigarettes ☐cigars ☐pipe ☐marijuana

How much do you smoke? _____

79. If you quit smoking, describe your past smoking habits: ***how much & how long***?

_____

When did you quit smoking? _____

☐ I never smoked

80. How ***often*** do you have a drink containing alcohol?

- ☐ I never drank alcohol in my life
- ☐ Never
- ☐ Monthly or less
- ☐ 2-4x/month
- ☐ 2-3x/week
- ☐ 4 or more times/week

81. How many standard drinks containing alcohol do you have on a ***typical day***?

- ☐ 1-2
- ☐ 3-4
- ☐ 5-6
- ☐ 7-9
- ☐ 10 or more

82. How often do you have six or more drinks ***on one occasion***?

- ☐ Never
- ☐ less than monthly
- ☐ 2-4x/month
- ☐ 2-3x/week
- ☐ 4 or more times/week

83. Do you drink any **caffeinated beverages**?

- ☐ **coffee** How much? _____
- ☐ **tea** How much? _____
- ☐ **soda w/ caffeine** How much? _____
- ☐ **energy drinks** How much? _____

Latest time of day you usually consume caffeine? _____

84. Current pets? _____

85. Have any close blood relatives* had the following problems?

*mother/father, brother/sister, son/daughter

sleep apnea ☐ Yes ☐ No ☐ Don't know **Who?**	**restless legs syndrome (RLS)** ☐ Yes ☐ No ☐ Don't know **Who?**
loud snoring ☐ Yes ☐ No ☐ Don't know **Who?**	**long-term insomnia** ☐ Yes ☐ No ☐ Don't know **Who?**
severe daytime sleepiness ☐ Yes ☐ No ☐ Don't know **Who?**	**narcolepsy** ☐ Yes ☐ No ☐ Don't know **Who?**
sleep walking ☐ Yes ☐ No ☐ Don't know	**death while sleeping** ☐ Yes ☐ No ☐ Don't know **Who?**
other sleep disorder ☐ Yes ☐ No ☐ Don't know **Who?** Describe sleep problem if yes:	

☐ I am adopted and don't know anything about my biological family medical problems

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86. Review of Systems

How tall are you? _____

- Have you lost height due to osteoporosis or other reasons? ☐Yes ☐No
- If so, how much height have you lost? _____

What is your neck/collar size (if known)? _____
What is your most recent weight? _____
Estimate your weight 1 year ago? _____
Estimate your weight 5 years ago? _____
Estimate your weight 10 years ago? _____
Estimate your weight at age 21? _____

Have you experienced any of these ***within past month***?

Yes	No	Constitutional
☐Y	☐N	loss of appetite
☐Y	☐N	weight loss
☐Y	☐N	weight gain
☐Y	☐N	chills or fevers
☐Y	☐N	heavy sweating at night
☐Y	☐N	fatigued/tired

Yes	No	Eye
☐Y	☐N	recent change in vision
☐Y	☐N	itchy eyes
☐Y	☐N	watery eyes
☐Y	☐N	dry eyes
☐Y	☐N	eye pain

Yes	No	ENT
☐Y	☐N	hearing loss
☐Y	☐N	ringing in ears
☐Y	☐N	impaired smell
☐Y	☐N	impaired taste
☐Y	☐N	frequent bad breath
☐Y	☐N	recurring nose bleeds
☐Y	☐N	sneezing
☐Y	☐N	nasal congestion
☐Y	☐N	nasal spray (e.g. Afrin, 4-way, Dristan)
☐Y	☐N	post-nasal drip
☐Y	☐N	frequently clear throat
☐Y	☐N	hoarse voice
☐Y	☐N	sore throat

Yes	No	Cardiovascular
☐Y	☐N	chest pain or pressure
☐Y	☐N	palpitations
☐Y	☐N	rapid heart beat

Yes	No	Respiratory
☐Y	☐N	cough
☐Y	☐N	sputum production
☐Y	☐N	coughing up blood
☐Y	☐N	trouble breathing with exertion
☐Y	☐N	trouble breathing lying down
☐Y	☐N	waking up at night with difficulty breathing
☐Y	☐N	wheezing
☐Y	☐N	chest tightness

Yes	No	Gastrointestinal
☐Y	☐N	nausea or vomiting
☐Y	☐N	difficulty swallowing
☐Y	☐N	pain when swallowing
☐Y	☐N	acid reflux
☐Y	☐N	heart burn
☐Y	☐N	bloated feeling
☐Y	☐N	excessive burping
☐Y	☐N	passing excessive gas

Name: DOB: Date form completed:

Have you experienced any of these ***within past month***?

Yes	No	Musculoskeletal
☐Y	☐N	muscle pain

Where?_____

☐Y	☐N	leg cramps at night
☐Y	☐N	joint pain

Where? _____

☐Y	☐N	joint stiffness

Where? _____

Yes	No	Skin
☐Y	☐N	current skin rash
☐Y	☐N	frequent itching
☐Y	☐N	current skin cancer
☐Y	☐N	other skin problem

Explain: _____

Yes	No	Neurologic
☐Y	☐N	recent seizure
☐Y	☐N	recent stroke
☐Y	☐N	memory loss
☐Y	☐N	hand tremor
☐Y	☐N	sensation of room spinning

Yes	No	Psychologic
☐Y	☐N	depression
☐Y	☐N	anxiety/nervousness
☐Y	☐N	hallucinations
☐Y	☐N	paranoid thoughts
☐Y	☐N	claustrophobia

Yes	No	Endocrine
☐Y	☐N	poor tolerance of cold
☐Y	☐N	poor tolerance of heat
☐Y	☐N	extreme thirst
☐Y	☐N	loss of interest in sex
☐Y	☐N	poor sexual function

Yes	No	Heme & Lymphatic
☐Y	☐N	anemia (low red cells)
☐Y	☐N	iron deficiency
☐Y	☐N	taking iron pills
☐Y	☐N	received iron infusions

Yes	No	Genitourinary system
☐Y	☐N	difficult-slow urination
☐Y	☐N	urinate at night?

How often? _____

☐Y	☐N	poor bladder control

Women only

Age at time of menopause? _____

Unusually prolonged or heavy bleeding?

☐ yes ☐ no