SLEEP QUESTIONNAIRE

Patient Name: _____Sex: _____ Date of Birth: _____

Occupation: _____Usual Work Hours/Days: _____

Referring Physician: _____Family Physician: _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night For how many months/years? _____

❑ Being sleepy all day For how many months/years? _____

❑ Snoring For how many months/years? _____

❑ Unwanted behaviors during sleep, explain
_____

❑ Other, explain _____

Sleep Pattern

	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.

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Desired wake up time: _____ a.m./p.m. _____ a.m./p.m.

How do you usually awaken?
i.e., alarm clock: _____ _____

Total amount of sleep per night: _____ _____

Please check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ My child usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

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Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Medical History

Vital Statistics

What is your: Height? ____ feet _____inches Weight? _____ pounds Neck Size: _____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Past Sleep Evaluation and Treatment

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

Past Medical History

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment

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- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Cancer
- ❑ Thyroid problems
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems
- ❑ Erectile dysfunction/impotence

Check any of the following symptoms you have had in the past 12 months:

- ❑ Frequent headaches
- ❑ Fainting or passing out
- ❑ Sudden loss of vision or strength
- ❑ Inability to speak
- ❑ Hearing loss or ringing in ear(s)
- ❑ Hoarseness for more than 2-4 weeks
- ❑ Nosebleeds
- ❑ Cough for more than 2-4 weeks
- ❑ Coughing up blood
- ❑ Shortness of breath or wheezing
- ❑ Swelling in feet or ankles
- ❑ Chest pain, tightness or pressure
- ❑ Weight loss of more than 5-10 lbs.
- ❑ Frequent heartburn / indigestion
- ❑ Abdominal pain
- ❑ Frequent constipation
- ❑ Frequent diarrhea
- ❑ Rectal bleeding / black stools
- ❑ Difficulty urinating / incontinence
- ❑ Blood in urine
- ❑ Urinating more than 2 times per night
- ❑ Pain in joints or bones
- ❑ Unusual bruising or bleeding
- ❑ Epilepsy / seizures
- ❑ Change in wart, mole or skin growth
- ❑ Difficulty swallowing or food "sticking"

Using the Answer Key below, please circle the number that best applies to your life over the past 6 months.

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Answer Key **1** – Never **2**- Rarely **3** – Sometimes **4** – Usually **5** – Always

I have trouble falling asleep	1	2	3	4	5
I wake up often during the night	1	2	3	4	5
At bedtime, thoughts race through my mind	1	2	3	4	5
At bedtime, I feel sad and depressed	1	2	3	4	5
When falling asleep, I feel paralyzed (unable to move)	1	2	3	4	5
When falling asleep, I have restless legs (creepy-crawly feelings, aching, or inability to keep legs still)	1	2	3	4	5
If I wake up during the night, I have trouble getting back to sleep because of restless legs or leg movements	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breathe	1	2	3	4	5
At night my heart pounds, beats rapidly, or beats irregularly	1	2	3	4	5
I sweat a great deal at night	1	2	3	4	5
My sleep is disturbed by sadness or depression	1	2	3	4	5
I have a lot of nightmares (frightening dreams)	1	2	3	4	5
I feel unable to move (paralyzed) after a nap	1	2	3	4	5
I have dream-like images (hallucinations) as I wake up in the morning, even though I know I am not asleep	1	2	3	4	5
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	1	2	3	4	5
I have been unable to sleep at all for several day	1	2	3	4	5
I feel that I have insomnia	1	2	3	4	5
I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
In the past 6 months I have fallen asleep while eating, talking to someone, riding in a bus or car, reading a book, watching TV or a movie, or listening to a lecture	1	2	3	4	5

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I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
I often have to let someone else drive the car because I am too sleepy to drive	1	2	3	4	5
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	1	2	3	4	5
I often am unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it	1	2	3	4	5
I get "weak knees" when I laugh	1	2	3	4	5
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion	1	2	3	4	5
My desire or interest in sex is less than what it used to be	1	2	3	4	5
I am unhappy about loving relationships in my life	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
I smoke tobacco within two hours before bedtime	1	2	3	4	5
I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	1	2	3	4	5
My snoring or my breathing problem is much worse if I sleep on my back	1	2	3	4	5
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	1	2	3	4	5

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BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Check any of the following behaviors that you have observed the patient doing **while asleep**:

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

_____

_____

_____

_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

_____

_____

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

_____

_____

_____

_____

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times, even if you have not done some of these things recently.

Use the following scale to choose the MOST APPROPRIATE NUMBER for each situation.

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

SITUATION

1.) Sitting and reading---------- _____

2.) Watching TV---------- _____

3.) Sitting inactive in a public place (ie: a theatre or meeting)---- _____

4.) As a passenger in a car for an hour without a break---------- _____

5.) Lying down to rest in the afternoon when circumstances permit _____

6.) Sitting and talking to someone---------- _____

7.) Sitting quietly after lunch without alcohol---------- _____

8.) In a car, while stopped for a few minutes in traffic ---------- _____

TOTAL---------- _____

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