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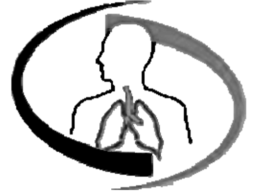

SLEEP QUESTIONNAIRE

PATIENT NAME ______________________________ **DATE OF BIRTH** ____________________

WHAT IS THE MAIN REASON FOR YOUR VISIT TO THE SLEEP CENTER?______________________________

HOW LONG HAS THIS PROBLEM AFFECTED YOU?______________________________

HOW SERIOUS IS THIS PROBLEM FOR YOU? (circle one below)

☐ VERY SERIOUS ☐ MODERATELY SERIOUS ☐ MILDLY SERIOUS ☐ NOT SERIOUS

HAVE YOU EVER HAD A SLEEP STUDY BEFORE? YES ☐ NO ☐

IF YES, WHAT WERE THE RESULTS? ______________________________

SLEEP PATTERNS

	WORK DAYS	OFF DAYS
ACTIVITY PRIOR TO TURNING LIGHT OFF TO SLEEP	____________	____________
TYPICAL BEDTIME (e.g.10 PM)	____________	____________
TYPICAL TIME IT TAKES TO FALL ASLEEP (e.g. 15 minutes)	____________	____________
TYPICAL NUMBER OF AWAKENINGS	____________	____________
ACTIVITIES DURING AWAKENING (e.g. WATCHING TV, READING)	____________	____________
TYPICAL AMOUNT OF TIME NEEDED TO FALL BACK ASLEEP	____________	____________
TYPICAL WAKE UP TIME	____________	____________
DESIRED WAKE UP TIME	____________	____________
HOW DO YOU USUALLY AWAKEN? (e.g. ALARM CLOCK)	____________	____________
TOTAL AMOUNT OF SLEEP	____________	____________
NUMBER OF NAPS PER DAY	____________	____________
TYPICAL LENGTH OF NAP	____________	____________

DO YOU FEEL YOU GET TOO MUCH SLEEP AT NIGHT? ☐ YES ☐NO

DO YOU FEEL YOU GET TOO LITTLE SLEEP AT NIGHT? ☐ YES ☐NO

SLEEP HABITS

____ I FREQUENTLY TRAVEL ACROSS 2 OR MORE TIME ZONES

____I USUALLY WATCH TV OR READ IN BED PRIOR TO SLEEP

____ 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 HAVE TROUBLE FALLING ASLEEP

____THOUGHTS RACE THROUGH MY MIND WHEN I TRY TO FALL ASLEEP

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____I HAVE EXPERIENCED WEAKNESS OR PARALYSIS WHEN GOING TO SLEEP

____I HAVE AN ACIDIC STOMACH WHEN I SLEEP

____I EXPERIENCE CREEPING, CRAWLING OR TINGLING SENSATION IN MY LEGS WHEN I TRY TO FALL ASLEEP

____I AWAKEN FREQUENTLY DURING THE NIGHT

____I AM UNABLE TO EASILY RETURN TO SLEEP IF I AWAKEN

____I AM HUNGRY WHEN I AWAKEN DURING THE NIGHT

____I WILL EAT SOMETHING IF I AWAKEN DURING THE NIGHT

____I TYPICALLY AWAKE TO URINATE DURING THE NIGHT

____I HAVE NIGHTMARES OR DISTURBING DREAMS

____I SWEAT A GREAT DEAL DURING SLEEP

____I EXPERIENCE IRREGULAR OR SUDDEN, FAST HEARTBEAT

____I CANNOT SLEEP ON MY BACK

____I AWAKEN EARLY, AND STILL TIRED, BUT UNABLE TO RETURN TO SLEEP

____I AWAKEN FROM SLEEP WITH A HEADACHE

____I HAVE EXPERIENCED WEAKNESS OR PARALYSIS ON AWAKENING

____I EXPERIENCE SEEING THINGS OR HEARING VOICES THAT ARE NOT REAL

BREATHING

____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

____I AWAKEN AT NIGHT CHOKING, SMOTHERING OR GASPING FOR AIR

____I HAVE BEEN TOLD THAT I STOP BREATHING WHILE ASLEEP

RESTLESSNESS

____I AM A RESTLESS SLEEPER

____I KICK OR JERK MY LEGS AND/OR ARMS DURING SLEEP

____I EXPERIENCE RESTLESSNESS, TINGLING OR CRAWLING SENSATION IN MY ARMS/LEGS

____I EXPERIENCE AN INABILITY TO KEEP MY LEGS STILL PRIOR TO SLEEP

____I TALK IN MY SLEEP

____I HAVE SLEEP WALKED AS AN ADULT

____I GRIND MY TEETH IN MY SLEEP

____I HAVE CHRONIC PAIN THAT PREVENTS ME FROM BEING COMFORTABLE TO SLEEP

DAYTIME SLEEPINESS

____I HAVE A TENDENCY TO FALL ASLEEP DURING THE DAY

____I HAVE EXPERIENCED LAPSES OF TIME OR BLACKOUTS

____I HAVE FALLEN ASLEEP WHILE DRIVING

____I HAVE HAD AUTO ACCIDENTS AS A RESULT OF FALLING ASLEEP

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____I FALL ASLEEP WATCHING TV

____I FALL ASLEEP DURING CONVERSATIONS

____I FALL ASLEEP DURING SEDENTARY SITUATIONS

____I PERFORM POORLY IN WORK/SCHOOL DUE TO SLEEPINESS

____I HAVE EXPERIENCED SUDDEN MUSCLE WEAKNESS IN RESPONSE TO EMOTION SUCH AS LAUGHTER, ANGER, ETC.

____I HAVE EXPERIENCED INABILITY TO MOVE WHEN FALLING ASLEEP OR AWAKENING

____I FEEL VERY FATIGUED DURING THE DAY

____I FEEL DEPRESSED DURING THE DAY

SOCIAL HABITS

DO YOU SMOKE? ☐ YES ☐ NO IF YES: AMOUNT _______packs HOW MANY YEARS _____________yrs

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES: TYPE FREQUENCY AMOUNT PER WEEK

☐ BEER ☐ DAILY ☐ WEEKENDS ___________ cans/week

☐ WINE ☐ DAILY ☐ WEEKENDS ___________ glasses/week

☐ LIQUOR ☐ DAILY ☐ WEEKENDS ___________ shots/week

DO YOU USE COCAINE OR CRACK? ☐ YES ☐ NO

DO YOU USE “UPPERS OR DOWNERS”? ☐ YES ☐ NO

DO YOU SMOKE MARIJUANA? ☐ YES ☐ NO

DO YOU USE OTHER NON-PRESCRIBED DRUGS? ☐ YES ☐ NO

IF YES, PLEASE LIST____

SOCIAL HISTORY

_____SLEEP ALONE _____SHARE A BED WITH SOMEONE _____SHARE A BEDROOM WITH SEPARATE BEDS

_____SHARE A BED WITH A PET _____PROVIDE ASSISTANCE TO SOMEONE DURING THE NIGHT (e.g. child, invalid etc)

IS YOUR SLEEP OFTEN DISTURBED BY? ____HEAT ____COLD ____NOISE ____BED PARTNER ____LIGHT ____OTHER

WHAT IS YOUR HEIGHT?______________YOUR WEIGHT?_______________________

WHAT WAS YOUR WEIGHT ONE YEAR AGO?_________ FIVE YEARS AGO?_________

FOR EACH BEVERAGE LISTED, WRITE IN THE AVERAGE NUMBER YOU DRINK PER DAY

REGULAR COFFEE ________ CUPS A DAY

DECAFFEINATED COFFEE ________ CUPS A DAY

TEA ________ CUPS A DAY

SOFT DRINKS WITH CAFFEINE ________CANS A DAY

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EMPLOYMENT STATUS

☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ STUDENT

IF EMPLOYED, WHAT ARE YOUR TYPICAL WORKING HOURS?_______________

____MY JOB REQUIRES DRIVING A VEHICLE

____I AM WORKING WITH DANGEROUS EQUIPMENT OR SUBSTANCES

____I AM A SHIFT WORKER ON ROTATING SHIFTS

____I AM A PERMANENT OR LONG TERM THIRD SHIFT (MIDNIGHT) WORKER

____IF A STUDENT, WHAT GRADE OR LEVEL ARE YOU IN___________________

EPWORTH SLEEP SCALE

The questions below are designed to assist us with evaluating your sleepiness during routine activities. Please answer these questions to the best of your ability. Even if you have not performed some or all of these activities, how do you think you would feel if you had? The question is asking you, how big is your chance of falling asleep during that situation.

Choose from the following scale, the most appropriate number for each situation:

0 = would NEVER fall asleep

1 = SLIGHT chance of falling asleep

2 = MODERATE chance of falling asleep

3 = HIGH chance of falling asleep

Situations	***Chance of Falling Asleep***
a) Sitting and Reading	______________________
b) Watching TV	______________________
c) Sitting, inactive in a public place (i.e. a theater or meeting)	______________________
d) As a passenger in a car for an hour without a break	______________________
e) Lying down to rest in the afternoon	______________________
f) Sitting and talking with someone	______________________
g) Sitting quietly after a lunch without alcohol	______________________
h) In a car, while stopped for a few minutes in traffic	______________________

TOTAL SCORE : _____________