SLEEP QUESTIONNAIRE

Name:_____

Today's Date: _____ Age (years): _____

Your Sex (M or F):_____ Height: _____ Weight:_____

Collar/Neck Size (inches) _____

Medications you are taking: _____

_____

_____

Medical conditions: ☐High blood pressure ☐Heart Disease ☐Diabetes

☐Stroke ☐Seizures/ Epilepsy ☐Sleep Apnea ☐Lung disease_____

THE EPWORTH SLEEPINESS SCALE

How likely are 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 try to work out how they would have affected you. 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	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

SLEEP - WAKE QUESTIONNAIRE

Patient's Name:_____ Date:_____

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MY MAIN COMPLAINT IS:

		YES	NO
1.	I have trouble sleeping at night	____	____
2.	I am sleepy all day	____	____
3.	I have unwanted behaviors when I am sleeping	____	____

If yes, explain:_____
_____

USUAL SLEEP HABITS

1. On weekdays (workdays), I usually go to bed at: _____
2. On weekdays (workdays), the earliest time in the last two weeks I have gone to bed is: _____
3. On weekdays (workdays), the latest time in the last two weeks I have gone to bed is: _____
4. My usual weekend (off days) bedtime is: _____
5. On weekdays, I wake up at: _____
6. On weekends, I wake up at: _____
7. To feel my best, I should go to bed at: _____
8. To feel my best, I should get up at: _____
9. In the evening, I usually start feeling tired at: _____
10. The amount of time that I usually take to fall asleep is: _____
11. I usually exercise at _____ for _____ minutes.
12. I wake up _____ naturally; _____by using alarm.
13. I take a nap about _____ days each week.
14. After taking a nap, I usually feel:
    _____ refreshed
    _____ groggy or sleepy.

SLEEP - WAKE QUESTIONNAIRE

Patient's Name:_____ Date:_____

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1. The number of times that I usually wake up during the night is: _____
2. The reason I wake up is: _____
3. My best estimate of the clock time(s) during the night that I wake up is (are): _____
4. If I wake up during the night, the time it usually takes for to fall asleep again is: _____
5. The total amount of time I am awake during the night after I first fall asleep is: _____
6. The dozing time I generally spend between awakenings in the morning and getting out of bed is: _____

Please place a check beside any of the following statements that are true for you:

_____ I have a job that involves shift work or night work.
_____ I frequently travel across times zones (east - west travel).
_____ I feel that sleep is a waste of time.
_____ I enjoy sleeping very much.
_____ I usually sleep with a bed partner.
_____ I sleep with earplugs or eye shades.

My usual sleep position is:

_____ on my back _____on my side
_____ on my stomach _____no single position is usual

I remember dreaming:

_____ rarely _____ about once a week
_____ a few times a week _____ nearly every night

Typically my dream recall is:

_____ only a vague feeling of having dreamed something
_____ a sketchy story, image or thought
_____ a fairly detailed and complex recollection

During the first 30 minutes after waking up in the morning, I usually feel:

_____ very groggy _____ somewhat drowsy
_____ slightly drowsy but awake _____ alert

PARASOMNIAS

Please place a check beside any of the following statements that are true for you.

_____ I have been told that I grind my teeth when I sleep.
_____ As an adolescent or child, I have been seen sleepwalking.

SLEEP - WAKE QUESTIONNAIRE

Patient's Name:_____ Date:_____

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_____ As an adolescent or child, I have been seen sleeptalking.
_____ My dreams are often very vivid.
_____ I feel that I dream too much.
_____ My dreams often awaken me.
_____ I often have frightening dreams.
_____ As an adult, I have wet my bed.
_____ I have been told that I bang or twist my head at night.

DISTURBED SLEEP

Please place a check beside any of the following statements that are true for you.

_____ I have been told that I snore very loudly.
_____ Sometimes a person can not sleep in the same room with me because he / she is bothered by my snoring.
_____ My bed covers are very messy in the morning.
_____ I am a very restless sleeper.
_____ I have been told that I kick or poke my bed partner while I am asleep.
_____ I have hallucinations or dreamlike images when I am not actually asleep but while falling asleep or waking up.
_____ I sometimes awaken with a choking sensation.
_____ I have been told that I stop breathing when I sleep.
_____ I have fallen out of bed.
_____ I have been told that I make rolling or rocking movements during sleep.
_____ I sometimes have felt paralyzed or unable to move when waking or falling asleep.
_____ I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness.
_____ I wake up from sleep with a feeling of muscle tension or tightness in my arms or chest.
_____ I have awakened from sleep once or more having vomited or with heartburn.
_____ When I wake during the night, I often have to get up and go to the bathroom.
_____ I sweat a lot when I sleep.
_____ I feel that the quality of my sleep is unsatisfactory.
_____ I have been told that my legs twitch or jerk while I am sleeping.
_____ Sometimes I wake up with a headache.

SLEEP - WAKE QUESTIONNAIRE

Patient's Name:_____ Date:_____

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INSOMNIA

Please place a check beside any of the following statements that are true for you.

_____ I have trouble falling asleep at night.
_____ When I do not sleep, I worry about it the next day.
_____ When I wake up during the night, I have trouble going back to sleep.
_____ I wake up in the morning long before I have to.
_____ Some nights, I never get to sleep no matter how hard I try.
_____ When I try to go to sleep, my mind races with many thoughts.
_____ At night when I go to bed I do not feel sleepy.
_____ I often sleep better in an unfamiliar bedroom, such as a hotel or motel room.
_____ When I try to fall asleep I become anxious or nervous.
_____ When I try to fall asleep I worry about whether or not I can sleep.
_____ When I try to fall asleep I often feel hungry or thirsty.
_____ When I try to sleep I feel pain.
_____ Pain often wakes me up or keeps me from going back to sleep.
_____ I have a creeping, crawling sensation in my legs when I lie down to sleep.
_____ When I do sleep, I feel that I sleep very well.
_____ I am a very light sleeper. I am easily awakened by noises.
_____ My sleep is disturbed because of bed partner.
_____ Heat or cold disturbs my sleep.
_____ Generally I get up in the middle of the night for a snack.

DAYTIME SLEEPINESS

Please place a check beside any of the following statements that are true for you.

_____ I have sometimes fallen asleep at very inappropriate times, such as while driving, eating or during a conversation.
_____ I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.
_____ I am frequently so sleepy during the day that my work is poor.
_____ I have had accidents or near-accidents when driving because I felt so sleepy.
_____ When I have no plans or appointments the next day, I frequently go to bed late (compared with my usual bedtime).
_____ I frequently do not feel sleepy at bedtime and stay up until it is late so that as a consequence I get too little sleep.

Patient's Name:_____ Date:_____

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_____ Other members of my family have been hyperactive or hyperkinetic as children.

_____ Other members of my family have the same problem that I do.

DAILY SLEEP LOG

To help us understand your sleep problem, we need a record of the times when you sleep, nap, and wake up during sleep. In addition, we need to know the times when you drink coffee, tea, and alcoholic beverages. It is important that you keep this record for one week. You should give your best guess at the time needed to fall asleep. If you can not recall exactly the time of some events, given your best guess. Each column begins a new day; the first column is an example for you to study. If you have any questions, call our office. The number is on page 1 of this questionnaire. A - indicates a.m. (morning); P - indicates p.m. (afternoon or evening).

Day of week	Monday							
Time went to bed	11 pm							
Time of final awakening	6:30 am							
Estimated time to fall asleep	20 min							
Time of awakening during sleep/length of time awake	1 am/ 10 min 4 am/ 35 min							
Coffee & tea number of cups & time drank	7a 1 8a 1 12p 2 4:30p 2							
Alcoholic drinks number & time drank	9p 2 11p 4							

Patient's Name:_____ Date:_____

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DAYTIME SLEEPINESS SCALE

Directions:

Rate your degree of sleepiness during the day by choosing the statement below that best describes your feeling at the time. Write the number of that statement in the appropriate box. Make this rating shortly after you awaken in the morning and every hour during the day. This chart may be carried with you.

1. Alert, wide awake, feeling vital, peak alertness.

2. Awake, able to concentrate, but not quite at peak.

3. Awake, but not fully attentive; responsive, but let down a little.

4. A little foggy, a little sleepy, losing interest, but still able to function.

5. Foggy, prefer to be lying down, slowed down.

6. Very sleepy, woozy, fighting sleep, almost in reverie.

Sleepiness Scale
Date Started:_____

	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
M																			
Tu																			
W																			
Th																			
F																			
Sa																			
Su																			

SLEEP - WAKE QUESTIONNAIRE

Patient's Name:_____ Date:_____

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TO BE COMPLETED BY BED PARTNER

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

_____ Loud snoring
_____ Light snoring
_____ Twitching of legs or feet during sleep
_____ Breathing pauses
_____ Grinding teeth
_____ Sleep-talking
_____ Sleep-walking
_____ Sitting up in bed not awake
_____ Rocking or banging head
_____ Kicking with legs during sleep
_____ Getting out of bed while not awake
_____ Biting tongue
_____ Becoming very rigid and / or shaking

How long have you been aware of the sleep behaviors that you checked above?

_____

_____

Describe the behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

If you have noticed snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"? _____