

SLEEP QUESTIONNAIRE

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gender:\_\_**M / F\_ **AGE:** \_\_\_\_\_\_\_\_\_

**Family Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pts. Ht:** \_\_\_\_\_\_\_\_\_ **Wt:** \_\_\_\_\_\_\_\_\_ **BMI:**\_\_\_\_\_\_\_\_

Describe in detail what your sleep problem is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has it been a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you now have or have you ever had:

High blood pressure? Yes / No Gerd/Reflux/Heartburn? Yes / No

Sinus problems/Allergies? Yes / No Recent weight loss/gain? Yes / No

Stroke/Seizures? Yes / No Frequent urination? Yes / No

Heart Problems/Chest Pain? Yes / No Diabetes/Thyroid problems? Yes / No

Depression/Anxiety? Yes / No Respiratory problems/Asthma? Yes / No

Tonsillectomy? Yes / No Chronic pain/Arthritis? Yes / No

Nasal fracture/Nasal surgery? Yes / No

List all other medical problems: How long?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

List all medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List all surgeries:** **Year:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**ANSWER THE FOLLOWING QUESTIONS ON A SCALE FROM 0 TO 4**

**0= Not at all 2= Moderate 4=Very great**

1. How great a problem do you have with sleepiness,

(feeling sleepy, struggling to stay awake during the daytime)? 0 1 2 3 4

1. How great a problem do you have with fatigue,

(tiredness, exhaustion, lethargy, even when you are not

sleepy)? 0 1 2 3 4

3. How much trouble do you have falling asleep at night? 0 1 2 3 4

4. Do you snore? 0 1 2 3 4

5. Do you hold your breath or stop breathing in your sleep? 0 1 2 3 4

6. Do you have gas, indigestion, or heartburn at night? 0 1 2 3 4

7. Do you have night sweats? 0 1 2 3 4

8. Do you wake up with a headache in the morning? 0 1 2 3 4

9. Do you wake up with a dry mouth? 0 1 2 3 4

10. Do you have trouble breathing through your nose? 0 1 2 3 4

11. How many times a night do you wake up to urinate? 0 1 2 3 4

12. Do you have difficulty breathing while lying down flat? 0 1 2 3 4

13. Do you have shortness of breath with exertion? 0 1 2 3 4

14. Do you have choking with meals? 0 1 2 3 4

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15. When you awaken from sleep, do you ever feel paralyzed,

unable to move even though you are awake? 0 1 2 3 4

16. When someone startles you or makes you laugh, do you

get weak, fall, or do your knees buckle? 0 1 2 3 4

17. While in the process of falling asleep, do you have vivid

dreams or hallucinations? (Not all night long) 0 1 2 3 4

18. Do you have frequent uncontrollable bouts of sleep, sleep attacks,

or an irresistible urge to sleep? 0 1 2 3 4

19. Do you wake up gasping or short of breath? 0 1 2 3 4

20. Do your legs kick or twitch frequently during the night? 0 1 2 3 4

21. Do you have restless legs (crawling, itching or aching, an

inability to keep your legs still)? 0 1 2 3 4

22. Do you have problems with memory or concentration? 0 1 2 3 4

23. Problems with impotence or lack of sexual interest? 0 1 2 3 4

24. Are you irritable? 0 1 2 3 4

25. Do you feel depressed? 0 1 2 3 4

26. Do you feel anxious? 0 1 2 3 4

27. Do you grind your teeth at night? 0 1 2 3 4

28. Do you have to fight sleep while driving? 0 1 2 3 4

29. Have you ever had a car wreck caused by sleepiness? 0 1 2 3 4

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**SLEEP HISTORY**:

Usual bedtime on weekdays / workdays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual length of time to fall asleep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual wake up time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number awakenings in the night: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average total sleep time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel refreshed or restored in the morning? Yes / No

Do you nap during the day? Yes / No

If yes, number of naps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of naps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are naps refreshing? Yes / No

Usual bedtime on weekends / days off: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual wake up time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total sleep time per 24-hour day off: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you need to feel rested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP ENVIRONMENT:**

Do you read in bed? Yes / No

Do you watch television in bed? Yes / No

Do you share the bed with anyone? Yes / No

Does your bed partner have a sleep disorder? Yes / No

Do you have pets in the bedroom? Yes / No

What is the temperature in your bedroom? \_\_\_\_\_\_\_\_\_\_

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SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired or fatigued? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number in 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 0 1 2 3

Watching T.V. 0 1 2 3

Sitting, inactive in a public place (theatre, meeting, 0 1 2 3

classroom)

As a passenger in a car for an hour without a break 0 1 2 3

Lying down for a rest in the afternoon when circum- 0 1 2 3

stances permit

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

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SOCIAL HISTORY:

Have you ever smoked? Yes / No

If yes, for how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you quit smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your present occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your work hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated beverages? (coffee, tea, soda) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get regular exercise? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any unusual eating habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

Marital Status: Single Married Divorced Separated Widowed

Children: Number \_\_\_\_\_\_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living: Yes/No Age: \_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Living: Yes/No Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers: Ages: \_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters: Ages: \_\_\_\_\_\_\_\_\_\_\_\_ Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any members of your family have sleep problems? If so, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Now that you have completed our questionnaire, do you have any other comments you would like to add? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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