



## QUESTIONNAIRE FOR SLEEP PATIENTS

**PLEASE FILL THIS OUT AFTER DISCUSSING IT WITH YOUR BED PARTNER OR ROOMMATE.**

NAME : \_\_\_\_\_

DATE: \_\_\_\_\_

AGE: \_\_\_\_\_

Where did you hear about us? \_\_\_\_\_

### **SLEEP PROBLEM**

1. Briefly describe your main problem, how long you have had it and how it affects your day-to-day life.

2. Have you ever had a sleep study before for this problem?  Yes  No

If so, when, where and what were the results? \_\_\_\_\_

3. Please check all the following that apply to your sleep problem:

- Difficulty falling asleep
- Waking up during the night
- Difficulty falling back to sleep after waking in the night
- Waking up early in the morning (before expected time)
- Difficulty awakening in the morning
- Feeling like the quality of your sleep wasn't very good
- Sleepiness during the day
- Daytime fatigue even when you're not sleepy

4. Can you identify anything that either makes your nighttime sleep problem better or worse?  Yes  No

If so, please describe.

5. Can you identify anything that makes your daytime impairment better or worse?  Yes  No

If so, please describe.

6. How upsetting is this problem to you?

- mildly upsetting       moderately severe       severe       totally incapacitating

7. How much do you want help with your problem?

- a great deal       moderate amount       could do without it

8. Why do **you** think you have this particular sleep/wake problem?

**SLEEP ONSET**

1. What time do you usually go to bed on weekdays? \_\_\_\_\_ on weekends? \_\_\_\_\_
2. On average, how long does it usually take you to fall asleep after lights are turned off? \_\_\_\_\_  
If more than 30 minutes, how many time per week does this occur? \_\_\_\_\_
3. Do you consider yourself a morning person (“early bird”) or an evening person (“night owl”)? Yes No
4. During the past several years, have you taken any medications (prescribed or over-the-counter) or tried any therapies (e.g., meditation, relaxation, etc.) to help you sleep? Yes No If so, please describe effect.

<u>TREATMENT</u>	<u>EFFECT</u>
_____	_____
_____	_____
_____	_____
_____	_____

5. Do you have any routine before bedtime? Yes No If so, please describe.

	Yes/No	How often?	How long?	In the bedroom?
Read				
Watch TV				
Other media (computer, phone)				

6. Check all of the following that may keep you from falling asleep:
  - Thoughts racing through your mind
  - Worrying about things
  - Feeling sad or depressed
  - Feeling afraid of going to sleep
  - Experience vivid or frightening dream-like scenes (hallucinations) even though you know that you are awake
  - Feel unable to move (paralyzed)
  - Parts of your body startle or jerk
7. Do you experience persistent and uncomfortable feelings in your legs while sitting or lying down? Yes No  
If yes, please answer the following questions:
  - a. Is there a persistent need or urge to move your legs? Yes No
  - b. Are these uncomfortable feelings or urge to move your legs worse in the evening or night compared with the morning? Yes No
  - c. Do they disappear or improve when you are active or moving around? Yes No
  - d. How often do they disturb your ability to fall asleep? Every night  > 1-2 times a week  Rarely  Never
8. Do you suffer from chronic pain? Yes No If yes, please answer the following questions:
  - a. What diagnosis (either confirmed or provisional) have you been given by a professional regarding your chronic pain? \_\_\_\_\_
  - b. Is falling asleep impaired by pain? Yes No
  - c. Are you waking up at night due to pain? Yes No
  - d. Does your pain improve with sleep? Yes No

**DURING THE NIGHT**

1. How many total hours of sleep do you usually get at night? \_\_\_\_\_
2. How much sleep do you think you need to feel refreshed? \_\_\_\_\_
3. Do you sleep better in places other than your bed or bedroom? Yes No
4. What body positions do you sleep in? Back Sides Stomach Upright or head elevated
5. Do you usually awaken during the night? Yes No  
If so, how many times? \_\_\_\_\_ How long are you usually awake? \_\_\_\_\_ What keeps you awake? \_\_\_\_\_
6. If you do awaken during the night, is it:  
 Soon after falling asleep       Middle of the night       Early morning
7. Please rate the following questions about your sleep in the last 3 months:

	Never	Sometimes	Always
Sleep with <u>someone else</u> in your bed or room			
<u>Provide assistance</u> to someone during the night			
<u>Snore</u>			
<u>Snort</u> or <u>Awaken from your own snoring</u>			
Someone is bothered by your snoring			
Told that you <u>stop breathing</u>			
Wake up <u>gasping for air</u>			
Wake up <u>choking</u>			
Wake up <u>coughing</u>			
<u>Sweat</u> excessively			
<u>Move</u> excessively (toss and turn)			
Have <u>nasal congestion</u> or stuffiness			
Awaken with <u>dry mouth</u>			
Awaken with <u>headache</u> in the middle of the night			
Awaken with <u>palpitations</u>			
Awaken with sour taste or <u>heartburn</u>			
Awaken with an urgent desire to <u>urinate</u>			
If so, how many times? _____			
<u>Wet your bed</u> as an adult			
Have your sleep disrupted by <u>pain</u>			
Have your sleep disrupted by <u>light, noise, heat, cold</u> or <u>bed partner</u>			
<u>Grind</u> your teeth			
Have nights filled with intense <u>vivid dreams</u>			
Begin dreaming immediately after falling asleep			
Have <u>nightmares</u> or disturbing dreams			
Wake up because of a dream			
Have difficulty falling back asleep after waking from a dream			
Waken from sleep <u>screaming</u> and/or <u>confused</u>			
“ <u>Act out</u> ” your dreams			
Accidentally hurt yourself or your bed partner			
<u>Talk, walk</u> or <u>eat</u>			
Legs twitch or <u>kick</u>			
Have convulsions or <u>seizures</u>			

**AWAKENING IN THE MORNING**

1. Time of usual final awakening on weekdays \_\_\_\_\_ on weekends \_\_\_\_\_
2. Time you leave your bed on a typical morning \_\_\_\_\_
3. Time it takes to feel fully awake after getting out of bed \_\_\_\_\_ OR  Never feel fully awake
4. Please rate how often you:

Notice that you are unusually difficult to wake up in the morning  
 Depend on an alarm to wake up  
 Wake up with a morning headache  
 Feel unable to move (paralyzed) when waking up

Never	Sometimes	Always

### **DAYTIME FUNCTIONING**

1. 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, 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 theater or a 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 lunch without alcohol ..... \_\_\_\_\_  
 In a car, while stopped for a few minutes in traffic ..... \_\_\_\_\_

2. Do you take daytime naps?  Yes  No If yes, how often and for how long?

\_\_\_\_\_ Do you feel refreshed afterwards?  Yes  No If yes, for how long?

3. Have you recently:

- Felt sleppy while driving  
 Had accidents (work, auto) related to sleepiness  
 Had "near-accidents" related to sleepiness  
 Felt fatigue (exhaustion, tiredness) even when you are not sleepy  
 Become increasingly irritable or short-tempered  
 Found that your mind is not working as quickly or effectively as it used to  
 Had decreased desire for sexual activity  
 Felt depressed or anxious

	How Often or How Long?
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Have you ever had episodes of sudden muscular weakness (eg, buckling of your knees) when laughing, angry or emotional?  Yes  No

5. How much of the following do you have?

	<u>IN A USUAL 24 HOUR PERIOD:</u>	<u>WITHIN 8 HOURS OF GOING TO SLEEP:</u>
Coffee	_____ cups	_____ cups
Caffeinated Tea	_____ cups	_____ cups
Soda/Pop	_____ bottles/cans	_____ bottles/cans
Other caffeinated drinks	_____	_____
Stimulant medications	_____	_____

6. How many alcoholic drinks do you have during a usual 24 hour period?

	<u>WEEKDAYS</u>	<u>WEEKENDS</u>	<u>WITHIN 2 HOURS OF GOING TO SLEEP:</u>
Bottles (cans) of beer	_____	_____	_____
Glasses of wine	_____	_____	_____
Shots of liquor	_____	_____	_____

7. Do you use or have you used tobacco products?  Yes  No If yes, how much and for how long? \_\_\_\_\_  
If quit, when? \_\_\_\_\_

8. Do you use or have you used other illicit drugs?  Yes  No If yes, which ones and for how long? \_\_\_\_\_

## GENERAL HEALTH

1. Please check the following you have, or have had, problems with:

### **General**

\_\_\_ Weight loss  
\_\_\_ Weight gain  
\_\_\_ Chronic pain

### **Eyes**

\_\_\_ Eye disease

### **Ears/Nose/Throat/Neck**

\_\_\_ Hearing loss  
\_\_\_ Nasal allergies  
\_\_\_ Runny nose  
\_\_\_ Post-nasal drip  
\_\_\_ Nose bleeds  
\_\_\_ Sinusitis  
\_\_\_ Nasal polyps  
\_\_\_ Deviated septum  
\_\_\_ Jaw pain or clicking  
\_\_\_ Dentures  
\_\_\_ Orthodontics (braces)  
\_\_\_ Over-bite  
\_\_\_ Under-bite  
\_\_\_ Jaw surgery  
\_\_\_ Tonsillectomy  
\_\_\_ Adenoidectomy  
\_\_\_ Sinus surgery  
\_\_\_ Neck surgery

### **Cardiovascular**

\_\_\_ High blood pressure  
\_\_\_ High cholesterol  
\_\_\_ Heart disease  
\_\_\_ Heart failure  
\_\_\_ Abnormal heart rhythm  
\_\_\_ Angina  
\_\_\_ Swelling of the ankles  
\_\_\_ Heart surgery  
\_\_\_ Angioplasty  
\_\_\_ Pacemaker  
\_\_\_ Murmurs

### **Respiratory**

\_\_\_ Hoarseness  
\_\_\_ Chronic cough  
\_\_\_ Shortness of breath  
\_\_\_ Chest pain or tightness  
\_\_\_ Wheezing  
\_\_\_ Asthma  
\_\_\_ Chronic bronchitis  
\_\_\_ Emphysema

### **Gastrointestinal**

\_\_\_ Difficulty swallowing  
\_\_\_ Heartburn  
\_\_\_ Ulcer  
\_\_\_ Liver disease

### **Urologic**

\_\_\_ Kidney disease  
\_\_\_ Prostate problems  
\_\_\_ Loss of urine involuntarily

### **Skin/Musculoskeletal**

\_\_\_ Skin disease  
\_\_\_ Rash  
\_\_\_ Muscle or joint pain  
\_\_\_ Scoliosis  
\_\_\_ Arthritis  
\_\_\_ Fibromyalgia

### **Endocrine**

\_\_\_ Diabetes  
\_\_\_ Heat/cold intolerance  
\_\_\_ Cold hands/feet  
\_\_\_ Impotence  
\_\_\_ Thyroid imbalance  
\_\_\_ Menstrual disorders  
\_\_\_ Postmenopausal

### **Hematology/Oncology**

\_\_\_ Anemia  
\_\_\_ Cancer: type \_\_\_\_\_

### **Allergic/Immunologic**

\_\_\_ HIV infection or AIDS

### **Psychiatric**

\_\_\_ Depression  
\_\_\_ Anxiety/Panic attacks  
\_\_\_ Bipolar disorder  
\_\_\_ PTSD  
\_\_\_ ADD/ADHD  
\_\_\_ Poor concentration  
\_\_\_ Mood swings  
\_\_\_ Suicidal thoughts  
\_\_\_ Mental, physical or sexual abuse  
\_\_\_ Excessive energy  
\_\_\_ Claustrophobia

### **Neurologic**

\_\_\_ Chronic headaches  
\_\_\_ Numbness or tingling  
\_\_\_ Memory loss  
\_\_\_ Tremor  
\_\_\_ Loss of balance  
\_\_\_ Head injury  
\_\_\_ Meningitis  
\_\_\_ Seizures  
\_\_\_ Epilepsy  
\_\_\_ Stroke

2. Are there any other illnesses you have had that are not mentioned above?

3. Please list hospital admissions (including medical and psychiatric) and surgical operations:

<u>YEAR</u>	<u>REASON FOR ADMISSION OR SURGERY</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Please list all current medications (including non-prescription medications):

<u>NAME</u>	<u>DOSAGE PER DAY</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Do you have allergies to medications? Yes No If yes, please explain adverse reaction.

6. Does anyone in your family have any of the following:

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Snoring                | <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Hypertension or Heart disease |
| <input type="checkbox"/> Sleep apnea            |                                     | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Diabetes                      |

7. Are you employed outside your home? Yes No If yes, what is your present occupation? \_\_\_\_\_

Are you a shift worker? Yes No

If yes, what shift do you usually work? Day shift Night shift Rotating shift

8. With whom are you now living? (spouse, partner, children, parents, etc., please list first names and ages)

9. What is/was your body weight:

- Now: \_\_\_\_\_ pounds
- 6 months ago: \_\_\_\_\_ pounds
- 2 years ago: \_\_\_\_\_ pounds
- At age 20: \_\_\_\_\_ pounds
- At your heaviest: \_\_\_\_\_ pounds

10. Do you do any physical exercise? Yes No If yes, what do you do, when, and how often? \_\_\_\_\_

**Thank you so much for taking the time to fill out this questionnaire.  
It will aid us greatly in helping you with your sleep problems.**