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 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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
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<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<tr>
<td>Sitting, inactive in a public place (e.g. a theatre or meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
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</tbody>
</table>
SLEEP - WAKE QUESTIONNAIRE

Patient’s Name:_____________________________________ Date:____________________

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MY MAIN COMPLAINT IS:

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 time 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).

<table>
<thead>
<tr>
<th>Day of week</th>
<th>Monday</th>
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<tbody>
<tr>
<td>Time went to bed</td>
<td>11 pm</td>
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<tr>
<td>Time of final awakening</td>
<td>6:30 am</td>
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<tr>
<td>Estimated time to fall asleep</td>
<td>20 min</td>
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<tr>
<td>Time of awakening during sleep/length of time awake</td>
<td>1 am/10 min 4 am/35 min</td>
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<tr>
<td>Coffee &amp; tea number of cups &amp; time drank</td>
<td>7a 1 8a 1 12p 2 4:30p 2</td>
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<tr>
<td>Alcoholic drinks number &amp; time drank</td>
<td>9p 2 11p 4</td>
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SLEEP - WAKE QUESTIONNAIRE
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.

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*Sleepiness Scale*
*Date Started:_________________
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“?

__________________________________________________________________________