# SLEEP QUESTIONNAIRE

Patient Name: ___________________________Sex: ________ Date of Birth: _______________

Occupation: ___________________________Usual Work Hours/Days: _________________

*Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.*

**My Main Sleep Complaint(s) Is:**

- ❑ Trouble sleeping at night For how many months/years? ________
- ❑ Being sleepy all day For how many months/years? ________
- ❑ Snoring For how many months/years? ________
- ❑ Unwanted behaviors during sleep, explain

______________________________________________________

**Sleep Pattern**

| | Work Days (Weekday) | Off Days (Weekends) |
|---|---|---|
| Typical bedtime: | _________ a.m./p.m. | _________ a.m./p.m. |
| Typical wake up time: | _________ a.m./p.m. | _________ a.m./p.m. |
| Total amount of sleep per night: | ________ | |

Please check all of the following statements that are true about your sleep:

**Sleep Habits**

- ❑ 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 typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep



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**Breathing**

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ 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

**Restlessness**

- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

**Daytime Sleepiness**

- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

**Social History**

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

**Employment Status:**

❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker



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## Vital Statistics

What is your: Height? ____ feet _____inches Weight? ______ pounds Neck Size: __________

## Past Sleep Evaluation and Treatment

- ☐ I have had a previous sleep disorder evaluation
- ☐ I have had a previous overnight sleep study
- ☐ I have been prescribed a CPAP or bi-level PAP machine for home use
- ☐ I have had surgical treatment for a sleep disorder
- ☐ I have previously been prescribed medication for a sleep disorder

## EPWORTH SLEEPINESS SCORE

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.

Use the following scale to choose the most appropriate number for each situation

0= never doze
1= slight chance
2= moderate chance
3= high chance

1. Sitting and reading ______
2. Watching TV ______
3. Sitting inactive in a public place (ie: theatre or meeting) ______
4. As a passenger in a car for an hour without a break ______
5. Lying down to rest in the afternoon when circumstances permit ______
6. Sitting and talking to someone _______
7. Sitting quietly after lunch without alcohol ________
8. In a car, while stopped for a few minutes in traffic _______

Total: __________



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**BED PARTNER QUESTIONNAIRE**

**Name of Patient:** ___________________________________ **Date:** ______________________________

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

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?
________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

______________________________________________________________

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

_____________________________________________________

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

_____________________________________________________



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