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# The Center for Respiratory and Sleep Disorders

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## SLEEP QUESTIONNAIRE

Your answers to the following questions will help us to obtain a better understanding of your sleep problems. Please answer every question to the best of your ability. It is helpful to discuss the answers with someone who has witnessed your problems, such as a spouse or bed partner.

### BACKGROUND INFORMATION

Date:

Name:

Age:

Sex:

Occupation:

Your Approximate Height:

Weight:

Please briefly describe your sleep or sleep problem

When did your sleep problem begin?

Have you seen any other doctors for your sleep problem Yes No If yes, who?

Have you ever had a sleep study? Yes No If yes, where?

Have you ever been treated for snoring, sleep apnea, sleepiness or insomnia?

Has your weight changed? Yes No If yes: How much? How long?

### MEDICAL HISTORY

Have ever been told by a doctor that you have:

YES

Hypertension (high blood pressure)

Thyroid gland problems

Heart attack

Angina

Stroke

Cancer

YES

Asthma

Emphysema or Chronic Bronchitis

Depression or other psychiatric disorder

Sinusitis

Diabetes

**MEDICAL HISTORY**

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Do you have other medial problems? If so, please list them here:

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Have you ever had:

YES

- Tonsillectomy (tonsils taken out)
- History of trauma
- other surgeries:

**MEDICATIONS**

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List the medications that you currently take (including the ones you can get without a prescription):

Name	Dose	Name	Dose

Do you ever use sleep pills, tranquilizers or sedatives?    Yes    No    If yes, please list.

Name	Dose	Name	Dose

Allergies  
Please list all drugs that you are allergic to:

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**FAMILY HISTORY**

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Yes    No        Does anyone in your family snore or been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorder? If yes, please list:

Yes    No        Has anyone in your family been diagnosed with one of the disorders listed under the medical history? If yes, please list:

**SOCIAL HISTORY**

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Children:

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Please list with whom live:

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## 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

### Chance of Situation 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

### Total

### SLEEP SYMPTOMS

### IS IT GETTING WORSE?

1. Do you snore?	YES NO	YES NO
2. Does your snoring or kicking prevent somebody from sleeping in the same bed with you?	YES NO	YES NO
3. Do you wake up gasping or feeling you cannot breathe?	YES NO	YES NO
4. Has your bed partner ever told you that you stop breathing during sleep?	YES NO	YES NO
5. Do you waken with a headache?	YES NO	YES NO
6. Do you have a restless or creepy feeling in your legs that is decreased by moving your legs or walking or prevents you from sleeping?	YES NO	YES NO
7. Has your bed partner ever noticed leg movements while you were sleeping?	YES NO	YES NO
8. Does your bed partner complain that you kick them during the night?	YES NO	YES NO
9. Do you toss and turn?	YES NO	YES NO

		IS IT GETTING WORSE?
10. Do you waken feeling tired, disoriented, foggy?	YES NO	YES NO
11. Have you ever had an automobile accident related to sleepiness?	YES NO	YES NO
12. Have you ever had accidents at work related to sleepiness?	YES NO	YES NO
13. Do you ever find yourself somewhere and do not know how you got there?	YES NO	YES NO
14. Do you have vivid dreams shortly after falling asleep at night?	YES NO	YES NO
15. Do you ever feel that you cannot move after lying down or just after you awaken?	YES NO	YES NO
16. Do you ever feel sudden weakness in your limbs when laughing emotional?	YES NO	YES NO
17. When you waken, are you short of breath or wheezing?	YES NO	YES NO
18. Do you grind your teeth at night?	YES NO	YES NO
19. Do you have trouble going to sleep?	YES NO	YES NO
20. Do you awaken during the night for no apparent reason?	YES NO	YES NO
21. Do you awaken during the night and have trouble going back to sleep?	YES NO	YES NO
22. Do you awaken early in the morning and cannot go back to sleep?	YES NO	YES NO
23. Do you awaken at night with thoughts racing through your mind?	YES NO	YES NO
24. Do you get up more than once a night to urinate?	YES NO	YES NO
25. Do you have difficulty falling asleep or awaken frequently through the night because of pain?	YES NO	YES NO
26. Do you watch T.V., read, eat, etc. in bed?	YES NO	YES NO
27. Do you fall asleep more easily on the couch than in bed?	YES NO	YES NO
28. Are you easily awakened by noise or light?	YES NO	YES NO
29. Do you feel frustrated or tense when seeing your bed or bedroom?	YES NO	YES NO
30. Have you felt depressed recently?	YES NO	YES NO
31. Have you been having any marital conflict lately?	YES NO	YES NO
32. Do you have very much job stress?	YES NO	YES NO
33. Do you find it difficult to get out of bed in the morning?	YES NO	YES NO
34. Is your job or school performance affected by you sleep problem?	YES NO	YES NO
35. Do you and your bed partner have similar bedtimes?	YES NO	
36. If your have a regular bed partner, do they sleep better or worse than you?		_____
37. How do you sleep away from home (e.g. on vacation)?		_____
38. What do you do after awakening in the night?		_____