The Center for Respiratory and Sleep Disorders

Sleep Questionnaire

Your answers to the following questions will help us 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 family member, spouse, or bed partner.

BACKGROUND INFORMATION Date ______________________________

Name____Age ________ Sex______________

Occupation____

Shift times____ Neck size____________________

Height___________________________ Weight___________________________

Briefly describe your sleep or sleep problem____

____

When did your sleep problem begin? ____

____

Has anyone ever told you that you stopped breathing during sleep? Yes No

Are you sleepy during the day? Yes No

Have you seen any other doctors for your sleep problems? Yes No

If yes, who? ____

Have you ever had a sleep study? Yes No

If yes, when? (Please obtain copy of report) ____

Have you ever been treated for snoring, sleep apnea, sleepiness or insomnia? Yes No

Do you have a home care company? Yes No

If yes, who? ____

MEDICAL HISTORY

Have you ever been told by a doctor that you have: (check all that apply)

____ Hypertension (high blood pressure)

____ Thyroid gland problems

____ Emphysema, chronic bronchitis or asthma

____ Sinusitis

____ Cancer

____ Migraine headaches

____ Heart attack

____ Depression or other psychiatric disorder

____ Stroke

____ Diabetes

Do you have any other medical problems? If so, please list them: ______________________________

____

____

Have you ever had: (check all that apply)

____ Tonsillectomy (removal of tonsils)

____ Other surgeries? If so, list them: ____

____

SLEEP HABITS	Work Days	Non-work Days
What time do you go to bed?	______________am pm	______________ am pm
What time do you get up?	______________am pm	______________ am pm
How long does it take you to go to sleep?	______________ min	______________ min
On average, how many hours of actual sleep do you get nightly?	_______________ hours	______________ hours
Do you return to bed after arising?	______Yes _____ No	_____Yes _____No
What time do you go to work/school?	______________am pm	______________am pm
What time do you return home?	______________am pm	______________am pm
Does your job require working different shifts?	_____Yes _____No	
If yes, which shifts?	____	
How many naps do you take during the day?	___________________	____________________
How many naps do you take during the evening?	__________________	____________________

SLEEP SYMPTOMS		Is it getting worse?
Do you snore?	Yes No	Yes No
Does your snoring or kicking prevent somebody from sleeping in the same bed as you?	Yes No	Yes No
Do you wake up gasping or feeling you can't breathe?	Yes No	Yes No
Has your bed partner ever told you that you stopped breathing during your sleep?	Yes No	Yes No

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			Is it getting worse?	
Do you awaken with a headache?	Yes	No	Yes	No
Do you have a restless or creepy feeling in your legs that prevents you from sleeping or is decreased by moving your legs or walking?	Yes	No	Yes	No
Has your bed partner ever noticed leg movements while you were sleeping?	Yes	No	Yes	No
Does your bed partner complain that you kick them during the night?	Yes	No	Yes	No
Do you toss and turn?	Yes	No	Yes	No
Have you ever had an accident related to sleepiness?	Yes	No	Yes	No
Do you have vivid dreams shortly after falling asleep?	Yes	No	Yes	No
Do you ever feel that you cannot move after lying down or just after you awaken?	Yes	No	Yes	No
Do you ever feel sudden weakness in your limbs when you are laughing or are emotional?	Yes	No	Yes	No
Do you have trouble going to sleep?	Yes	No	Yes	No
Do you watch TV, read, eat, etc. in bed?	Yes	No	Yes	No
Have you felt depressed recently?	Yes	No	Yes	No
Do you have very much job stress?	Yes	No	Yes	No

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 (like a theater or 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…………………….	________
Total	________