Sleep Disorders Questionnaire

Name: __________________________________________ Age _____ Height ______

Sex _____ Weight ______

Referring Physician: __________________________________________

Family Physician: _____________________________________________

Please consult your spouse/bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write in your own if one of the choices does not apply.

1. Please describe your sleep problem as best you can: ____________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________

2. What is the most you have ever weighed? _____________________________________________
   What did you weigh 5 years ago? ____________________________________________________
   What did you weigh 1 year ago? _____________________________________________________

3. When did your sleep problem begin? (month and/or year) ______________________________

4. Have you ever had a sleep study before?  YES  NO
   If yes, where was the test performed? _______________________________________________
   When was the test performed? _______________________________________________________
   What were the results? _____________________________________________________________

5. My ideal amount of sleep is ___________ hours per night.

   During the week I usually:
   Go to bed at _______________ (Time)
   Get up at _______________ (Time)
   Sleep a total of _______________ (Hours)

   During the weekend I usually:
   Go to bed at _______________ (Time)
   Get up at _______________ (Time)
   Sleep a total of _______________ (Hours)

6. My job requires shift work.  YES  NO
   If yes, my hours are: __________________________________________________________________

7. It usually takes me ______________________ minutes to fall asleep.

8. I usually wake up ____________________ time(s) during the night.
   Please explain what wakes you up:
   _______________________________________________________________________________
9. I have difficulty going back to sleep once I wake up.  YES  NO

10. I snore:
   Nightly   Weekly   Rarely   Never

11. My snoring started at age: ______________

12. I snore in all sleeping positions.  YES    NO

13. My snoring has been described as: Mild Moderate Loud

14. I have problems with my nose or nasal breathing  YES    NO
   If yes, please explain:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

15. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:
   Nightly   Weekly   Rarely   Never

16. I have been told that I toss and turn to an extreme amount.
   Nightly   Weekly   Rarely   Never

17. Immediately after falling asleep, I dream.
   Nightly   Weekly   Rarely   Never

18. I have been told that I talk or scream in my sleep.
   Nightly   Weekly   Rarely   Never

19. I have been told that I grind my teeth while I sleep.
   Nightly   Weekly   Rarely   Never

20. I wake up with a sour or stomach acid taste in my mouth.
   Nightly   Weekly   Rarely   Never
   Last meal is eaten at what time? ___________ a.m./p.m.

21. I wake up with my heart beating irregularly.
   Nightly   Weekly   Rarely   Never

22. I wake up at night with pains.
   Nightly   Weekly   Rarely   Never
23. I have the feeling of burning or tingling in my legs or the feeling or restless legs.
   Nightly  Weekly  Rarely  Never

24. I feel like I cannot move after lying down, before going to sleep.
   Nightly  Weekly  Rarely  Never

25. I see or hear things that are not real when lying in bed, but not asleep.
   Nightly  Weekly  Rarely  Never

26. After a typical night’s sleep, I feel:
   Refreshed  Fairly Rested  Somewhat Tired  Very Drowsy

27. I take naps.  YES  NO
   If yes, how many per day? ____________
   If no, is there any reason why you do not take naps?
   No Need  No Time  Work/Social Situation Does Not Permit

28. I fight sleep uncontrollably for short periods of time while sitting.
   Daily  Weekly  Rarely  Never
   This occurs when (circle each that applies):
   Watching TV  During Meetings  At the Movies  Riding in a Car
   Other: ___________________________________________________________________

29. I fight sleep when driving
   Nightly  Weekly  Rarely  Never
   This last occurred when? ____________________________________________
   This primarily occurs (circle the one that applies): Morning  Afternoon  Evenings

30. I have fallen asleep while driving a car.  YES  NO
   If yes, how many times? ____________________________________________
   Approximate date of last occurrence: ________________________________
   Please describe the circumstances: ____________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
31. I dream during my naps.
   Nightly     Weekly     Rarely     Never

32. After my naps, I feel:
   Refreshed   Fairly Rested   Somewhat Tired   Very Drowsy

33. I feel sudden weakness in my knees, neck, jaw, or arms when I get angry, sad, while laughing or when emotional.
   Daily       Weekly       Rarely       Never

34. Drowsiness is greatest in the:
   Morning     Afternoon     Evening

35. Within the last year, depression, anxiety, stress, or any other psychiatric abnormalities has interfered with my sleep:
   YES         NO
   If yes, please explain: ___________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________

36. Is there a history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring?
   YES         NO
   If yes, please explain: ___________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________

37. I have lost interest in sex or have trouble functioning sexually.
   Nightly     Weekly     Rarely     Never

38. My spouse or bed partner has noticed that I quit breathing at night.
   Nightly     Weekly     Rarely     Never

39. I have headaches in the morning.
   Nightly     Weekly     Rarely     Never
40. Underline any of the following that apply to you:

- Alcoholism
- Over ambitious
- Nightmares
- Depressed
- Don’t like weekends/vacations
- Home conditions bad
- Financial problems
- Feel panicky

- Suicidal ideas
- Can’t make decisions
- Feel Tense
- Insomnia
- Shy with people
- Can’t keep a job
- Take sedatives

- Take drugs
- Inferiority feelings
- Unable to have a good time
- Unable to Relax
- Can’t make friends
- Concentration difficulties
- No appetite

41. Do you usually: (Check all that apply to you)

- Sleep with someone else in your bed
- Sleep with someone else in your room
- Provide assistance to someone during the night (child, invalid, bed partner, animal)