Olathe HEALTH
Consultants in
Pulmonary Medicine

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

   _____

PATIENT NAME: _____ **DATE:**_____

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: _____

    _____

    _____

    _____

PATIENT NAME: _____ **DATE:**_____

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

PATIENT NAME: _____ **DATE:**_____

40. Underline any of the following that apply to you:

Alcoholism	Suicidal ideas	Take drugs
Over ambitious	Can't make decisions	Inferiority feelings
Nightmares	Feel Tense	Unable to have a good time
Depressed	Insomnia	Unable to Relax
Don't like weekends/vacations	Shy with people	Can't make friends
Home conditions bad	Can't keep a job	Concentration difficulties
Financial problems	Take sedatives	No appetite
Feel panicky		

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)