

Sleep Questionnaire

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Date of Birth: _____ Social Security: _____ Male Female

Height: _____ Weight: _____ Allergies: _____

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

1. Sitting and reading
2. Watching T.V.
3. Sitting, inactive in a public place (ex., theatre, meeting)
4. As a passenger in a car for an hour without a break
5. Laying 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

Johns, NW, A Method for Measuring Daytime Sleepiness, SLEEP, 14(6): 540-545

1. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

a. Have you ever consulted any of the following to help you with a sleep problem or daytimes sleepiness?
Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Obstetrician/Gynecologist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Other Internists | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Other Physician _____ | <input type="checkbox"/> Clergyman |

b. What treatment(s) have you received? _____

2. How often does this problem occur?

- Almost every night
- For periods of at least one week
- Irregularly
- Other _____

3. How long has this problem bothered you?

- Longer than two (2) years
- 1-2 years
- Several months
- Within the last three (3) months
- Within the last month

4. Please estimate the severity of your problem(s). Place an "X" on the line.

◆-----◆
Mildly Upsetting Moderately Severe Very Severe Extremely Severe Totally Incapacitating

5. How important is it to you to get help with your problems(s)? Place an "X" on the line.

◆-----◆
Very Important Important Moderately Important Not Important

6. How do you describe your sleep problem? Check all that apply to you.

- Difficulty falling asleep
- Wake up during the night
- When awoken at night, have difficulty falling back asleep
- Excessive daytime sleepiness
- Difficulty awakening

7. How long do you think normal people your age sleep? _____ hours/day
How long do you sleep? _____ hours/day

8. Write in the times you usually go to bed and get what time you get up.

Weekdays: Go to bed _____ Get up _____
Weekends: Go to bed _____ Get up _____

9. What type of bed do you sleep in?

- Box springs and mattress
- Waterbed
- Airbed
- Other _____

a. What size bed do you sleep in?

- King
- Queen
- Full
- Twin

b. How old is your sleeping surface? _____ years

c. Is your bed comfortable? Yes No

If not, explain why? _____

10. Do you have a regular bed partner? Yes No

If yes, has he/she ever complained about sleeping with you? Explain. _____

11. Do you use any of the following devices to aid in sleeping? Check all that apply.

- Fan
- Ear Plugs
- White noise
- Other _____

12. What do you do in the 30 minutes prior to turning out the lights and attempting to go to sleep? Describe your bedtime routine.

13. How long does it take you to fall asleep? _____ hours _____ minutes

14. What do you do if you are having trouble falling asleep?

15. Are you bothered by any of the following at night? Check all that apply.

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Heat/cold | <input type="checkbox"/> Bed partner |
| <input type="checkbox"/> Noise | <input type="checkbox"/> Not being in your usual bed |
| <input type="checkbox"/> Light | <input type="checkbox"/> Pets |
| <input type="checkbox"/> Children | <input type="checkbox"/> Other _____ |

16. Please rate how often you:

	Never	Rarely	Sometimes	Frequently	Constantly
Awaken from sleep short of breath					
Awaken at night with heartburn, belching or with cough or wheezing					
Snore					
Snore loudly enough that others complain					
Suddenly wake up gasping for breath during the night					
Have breathing problems during the night (observed by self or others)					
Sweat excessively during the night					
Notice your heart pounding or beating irregularly during the night					
Fall asleep during the day					
Fall asleep involuntarily					
Fall asleep while driving					
Fall asleep during physical effort					
Fall asleep when laughing or crying					
Experience loss of muscle tone when extremely emotional					
Have trouble at school or work because of sleepiness					
Feel unable to move (paralyzed) when waking up or falling asleep					
Experience vivid dream-like scenes upon awakening or falling asleep					
Feel afraid to go to sleep					
Have nightmares					
Remember your dreams					
Have racing thoughts					
Feel sad and depressed					
Have anxiety (worry about things)					
Have muscular tension					
Notice that parts of your body jerk					
Kick during the night					
Experience crawling and/or aching feeling in your legs					
Have morning jaw pain					
Grind teeth during sleep					
Are bothered by pain during the day					
Are bothered by pain during the night					
Wake up feeling stiff in the morning					
Injure yourself or others during sleep					
Wake up with pain in neck, spine or joints					
Wake up with sore or achy muscles					

17. At what time of day are you feeling the most alert and functioning best? _____ a.m. / p.m.
At what time of day are you feeling the least alert and functioning poorly? _____ a.m. / p.m.

18. Have you used any over the counter or prescription medications to aid you in sleeping? Yes No
If yes, what were they and how did they help you sleep? _____

19. Do you now, or have you in the past, used any forms of alternative medicine to aid you in sleeping?
 Yes No If yes, what were they and how did they help you sleep? _____

20. On average, how much caffeine do you consume per day? For each beverage listed, write in the typical amount you drink every day.

Coffee	_____	cups/day
Decaffeinated coffee	_____	cups/day
Tea	_____	cups/day
Soda/pop	_____	cups/day

21. On average, how many alcoholic beverages do you consume?

Weekdays	_____	drinks/day
Weekends	_____	drinks/day

22. On average, how many cigarettes, cigars or pipes do you use? _____ per day

23. Please list all of your medications you are currently taking: _____

