



SLEEP DISORDERS QUESTIONNAIRE

1. Patient Name: _____ Date: _____

2. Briefly describe your sleep problem. (If you have no sleep problem, please indicate why you were referred).

3. At what age did this problem begin? _____ years of age.

4. How does this affect your life and daily activities?

5. How serious is this problem for you? (Please indicate a vertical mark on the line below to indicate you answer).

Very serious _____ Not at all serious

6. Have you had any previous evaluations, examinations, or treatments for this sleep problem or any other problem with your sleep? Yes _____ No _____

If yes, briefly describe the evaluation, treatment and results.

7. Have you used any medication (prescribed or otherwise) to help your sleep problem?

Yes _____ No _____

If yes, list below

| Name | Amount | Frequency | How long Used? | How Useful? | Physician |
|------|--------|-----------|----------------|-------------|-----------|
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8. For each of the beverages listed, write in the average number you drink each day

Natural coffee _____ cups/day
Decaffeinated Coffee _____ cups/day
Tea _____ cups/day
Carbonated soft drinks _____ cups/day

9. If employed, what is your usual work schedule?

Start _____ am/pm

Stop _____ am/pm

Do your work shifts change? _____ Never _____ Infrequently _____ Regularly

10. What time do you usually go to bed and get up on *weekdays*?

Go to bed _____ am/pm

Get up _____ am/pm

What time do you usually go to bed and get up on the *weekends*?

Go to bed _____ am/pm

Get up _____ am/pm

On the average, how long does it take you to fall asleep at night after you turn off bedroom lights? _____ minutes

What do you ordinarily do just prior to turning out the lights and attempting to go to sleep?
(e.g. read, watch T.V., bathe, etc)

On the average, how often do you wake up during the night?

_____ times

11. On the average how long are you actually asleep at night?

_____ hrs _____ min

How do you ordinarily awaken?

Spontaneously _____ Alarm Clock _____ Other _____

How difficult is it for you to awaken and get out of bed after sleeping?

Very Difficult _____ Difficult _____ Sometimes Difficult _____ No problem _____

How long does it take you to be alert and functioning after sleeping?

_____ minutes

12. Are you bothered by sleeping during the day?

Yes _____ No _____

Do you usually feel tired during the day?

Yes _____ No _____

If yes, what do you attribute this to? _____

Do you feel you get too much sleep at night?

Yes _____ No _____

Do you feel you get too little sleep at night?

Yes _____ No _____

Have you been told you snore while asleep?

Yes _____ No _____

If yes, does the snoring disturb...

a) a bed partner or someone in the same room?

Yes _____ No _____

b) someone in the next room?

Yes _____ No _____

13. Do you find yourself falling asleep when you do not want to?

Yes _____ No _____

If yes, describe: _____

How long does the sleep episode last?

_____ hrs _____ mins

Do you feel rested or refreshed after the sleep episode?

Yes _____ No _____

Do you nap?

Yes _____ No _____

If yes, how many times per day _____. Average length of nap _____ hrs _____ mins

14. Do you wake up too early in the morning and re then unable to return to sleep?

Yes _____ No _____

15. Have you ever:

a. Suddenly fallen?

Yes _____ No _____

b. Experienced sudden bodily weakness?

Yes _____ No _____

If yes, to either of above, were you aware of the things around you?

Yes _____ No _____

Was the fall or weakness brought on by any particular even or feeling (anger, sadness, laughing)

Yes _____ No _____

If yes, briefly describe: _____

16. Have you ever experienced weakness or paralysis upon:

a. going to sleep

Yes _____ No _____

b. awakening from sleep

Yes _____ No _____

How often does this occur?

_____ times per week

17. Have you ever experienced seeing things and/or hearing voices or noises that were not real:

a. upon going to sleep?

Yes _____ No _____

b. during the night?

Yes _____ No _____

c. upon wakening from sleep?

Yes _____ No _____

d. during the day?

Yes _____ No _____

18. Do you have difficulty breathing at night?

Yes _____ No _____

If yes, briefly describe: _____

How often? _____ times a night. When did this first occur? _____ years of age

How did you become aware of this? _____

19. Have you ever experienced upon lying in bed before sleep or upon awakening sleep:

restless of legs _____ nervous legs _____ creeping/crawling sensation of legs _____

twitching _____ none _____

How often does this occur?

_____ times/week

How long does the sensation last?

_____ minutes (duration)

Does anything relieve the sensation (e.g. getting out of bed, medication, massage, etc?)

Yes_____ No_____

At what age did you first experience this?

_____years of age

20. Has anyone ever told you that arms or legs jerk or twitch while you are apparently asleep?

Yes_____ No_____

If yes, how often during the night does this occur?

_____times/night

How many night per week does this occur?

_____nights/week

At what age did this first come to your attention?

_____years of age

Does seem to awaken you from sleep?

Yes_____ No_____

21. Have you ever experienced doing something without being aware at the time of the action?

Yes_____ No_____

22. Have you ever acted out dreams?

Yes_____ No_____

How often does this occur?

_____times/week

23. Has anyone in your family been known to have any sleep problems?

Yes_____ No_____

If yes, please list the type of problem (e.g. trouble going to sleep, bed wetting, etc) and the person's relationship to you.

| TYPE OF PROBLEM | RELATIONSHIP | TREATED? |
|-----------------|--------------|----------|
| | | |
| | | |
| | | |
| | | |
| | | |

24. Do you know or do others tell you that you: (leave blank if not)

| | TIMES PER WEEK | AGE STARTED | LAST OCCURRED | TREATMENT |
|--|----------------|-------------|---------------|-----------|
| Talk while apparently asleep | | | | |
| Walk while apparently asleep | | | | |
| Grit teeth while apparently asleep | | | | |
| Wet the bed during sleep | | | | |
| Wake up screaming or afraid | | | | |
| Have disturbing dreams | | | | |
| Have unusual movements while apparently asleep | | | | |
| Awaken during the night with headaches | | | | |
| (Males) Have erections while asleep | | | | |

25. 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. 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 (e.g. a theater or meeting) | |
| As a passenger in a car for an hour without a break | |
| As a driver in a car, while stopped in traffic | |
| Lying down to rest in the afternoon when circumstances permit | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |

| <u>STOP-BANG Questionnaire</u> | Yes | No |
|--|-----|----|
| Do you S nore loudly (louder than talking or loud enough to be heard through closed doors)? | | |
| Do you often feel T ired, fatigued, or sleepy during the day? | | |
| Has anyone O bserved that you have stopped breathing while sleeping? | | |
| Do you have or are you being treated for high blood P ressure? | | |
| B MI more than 35 kg/m? | | |
| Are you more than 50 years of A ge? | | |
| Is your N eck 17 inches or greater for men (16 inches for women)? | | |
| Male G ender? | | |