

# Sleep Questionnaire

(Patient label here - office use)

**My main sleep problem is:** \_\_\_\_\_

**I have seen by a sleep specialist before:**  Yes  No

**I feel sleepy or fatigued during the day:**  Yes  No

**If YES:**

1. I've had this trouble for \_\_\_\_\_ years.

2. My sleep problem affects my ability to function at work  Yes  No

3. I take \_\_\_\_\_ naps a day for \_\_\_\_\_ minutes per nap.

Stanford Sleepiness Scale	Degree of Sleepiness	
This is a quick way to find out how you feel overall. Please read the descriptions to the right and put an X in the box next to the one that best describes how you normally feel during the day.	1. Feeling active, vital, alert or wide awake	<input type="checkbox"/>
	2. Functioning at high levels, but not at peak; able to concentrate	<input type="checkbox"/>
	3. Awake, but relaxed; responsive but not fully alert	<input type="checkbox"/>
	4. Somewhat foggy, let down	<input type="checkbox"/>
	5. Foggy; losing interest in remaining awake; slowed down	<input type="checkbox"/>
	6. Sleepy, woozy, fighting sleep; prefer to lie down	<input type="checkbox"/>
	7. No longer fighting sleep, sleep onset soon; having dream-like thoughts	<input type="checkbox"/>
	8. Asleep	<input type="checkbox"/>

**Estimated Sleepiness (Epworth Scale)**

How likely are you to doze off or fall asleep in the following situations, compared to feeling just tired?

This refers to your usual way of life recently. Even if you haven't done some of these things recently, circle the number that describes how each would have affected you. *(Circle one response for each row)*

Activity or situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car while stopped for a few minutes in traffic	0	1	2	3

**Please turn page over to continue**

**DO NOT SEND FOR SCANNING**

**On a typical day:**

1. I go to bed at \_\_\_\_\_ (PM | AM).
2. It takes me \_\_\_\_\_ minutes to fall asleep.
3. I wake up \_\_\_\_\_ times a night; I go to the bathroom \_\_\_\_\_ times a night.
4. I wake up at \_\_\_\_\_ (PM | AM); I actually get out of bed at \_\_\_\_\_ (AM | PM).
5. I estimate that my total sleep time is \_\_\_\_\_ hours.
6. I wake up in the morning feeling:  refreshed  unrefreshed

Snoring (as reported by your sleep partner)	(Circle one response for each row)			
	Never	Occasionally	Frequently	Don't know
1. My sleep partner tells me that I snore in my sleep	0	1	2	?
2. My sleep partner tells me that I snore loudly and bother others	0	1	2	?
3. My sleep partner tells me that I stop breathing (hold my breath) in my sleep	0	1	2	?
4. I snore so badly I wake myself up	0	1	2	?

**Habits:**

Caffeine use: \_\_\_\_\_ cups of caffeinated coffee/day \_\_\_\_\_ cups of other caffeinated beverages (soda pop, tea)/day

Alcohol use: \_\_\_\_\_ drinks per day OR \_\_\_\_\_ drinks per week

**Sleep related questions: (circle one)**

1. I grind my teeth when I'm asleep.  Yes  No ; I wear a night guard device at night.  Yes  No
  2. I've had problems with my jaw joint (TMJ [temporomandibular joint] discomfort).  Yes  No
  3. Heartburn wakes me up.  Yes  No
  4. I have jerky or tingly legs at rest (especially at night).  Yes  No
  5. Pain or discomfort makes it hard for me to sleep.  Yes  No
  6. When I wake up from sleep, I have a headache  Yes  No OR a dry mouth  Yes  No
  7. I have experienced a feeling of being paralyzed when awakening from sleep  Yes  No
  8. I act out my dreams  Yes  No; I walk in my sleep  Yes  No
  9. When going to sleep or awakening from sleep, I've had hallucinations (hearing or seeing things).  Yes  No
- Please list any medicine or substance you take to help you sleep: \_\_\_\_\_
- 

**Driving:**

1. Do you drive?  Yes  No
2. Do you have a commercial driver's license?  Yes  No
3. I've had about \_\_\_\_\_ near misses or accidents caused by drowsiness or sleepiness in the last 5 years.

**Other history:**

1. I have gained about \_\_\_\_\_ pounds in the last 5 years.
2. I have a family history of sleep disorders.  Yes  No
3. I have a family history of heart disease.  Yes  No
4. I have a family history of stroke.  Yes  No

**Occupation:** \_\_\_\_\_