

Patient's Name: _____

Date: _____

Date of Birth: _____

Chart # _____

SLEEP QUESTIONNAIRE

Thank you for helping us to take better care of you. Please complete the following information:

1. Please describe your sleep problem:			
2. How long ago did this problem begin?			
3. What does your spouse/significant other feel is your sleep problem?			
4. Have you ever been treated for this problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever had sleep testing before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are you using Oxygen?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Are you on: (circle one)	CPAP / BiPAP		
8. Do you snore?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you stop breathing while asleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you wake up choking or gasping for air?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. When you wake up in the morning, do you have:		Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry Mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Confusion or Lethargy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Low Mood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. How many times per night do you get up to go to the bathroom? (circle one)		0, 1, 2, 3, 4, 5	
13. Do you feel tired when you wake up?		<input type="checkbox"/> Frequently	<input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely
14. How restless is your sleep?		<input type="checkbox"/> Extremely	<input type="checkbox"/> Somewhat <input type="checkbox"/> Not at all
15. Is your sleep disturbed by:		Coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nasal Congestion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Heartburn/reflux?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Acting out dreams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Talking in your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Walking in your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Do you have a bed partner?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Do you have pets that sleep in your bed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Are you bothered by movements or snoring of others in your bed or in your room?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Do you leave the television on all night?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Is your bedroom dark and quiet at nights?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Do you eat or read in bed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Have you been diagnosed with a seizure disorder?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Does your bed partner tell you that you kick or jerk your legs (or your arms) frequently when you are asleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. When sitting or lying down, do you have uncomfortable or creepy-crawly sensations in your legs (and sometimes in other parts of your body), tied to a strong urge to move? (If NO, skip to # 28)		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date: _____

25. Do the sensations and urge to move bother you more in the evening and at night rather than during the day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Do other family members experience these same symptoms?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Do you have involuntary leg jerks when you are awake?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Do you often have trouble falling asleep or staying asleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Have you ever experienced sudden body or leg weakness brought on by laughter, surprise, fear, or when hearing or telling a joke? How often does this happen? Travis6316		<input type="checkbox"/> Yes	<input type="checkbox"/> No
30.			
31. Have you ever suddenly fallen to the ground without losing consciousness or fainting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Have you ever experienced seeing or hearing things that were not real just as you were going to sleep or just waking up?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Just as you are waking up or falling asleep, have you ever had the sensation that you cannot move although you are awake and aware of your surroundings?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
34. Do you wake up too early in the morning, unable to return to sleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. How do you ordinarily awaken?	<input type="checkbox"/> Spontaneously	<input type="checkbox"/> Alarm Clock	<input type="checkbox"/> Other
36. For each of the following, please write in the average number that you drink each day:		<u>Brand</u>	<u>Cups a day</u>
	Coffee		
	Tea		
	Carbonated beverages		
37. What are your usual working hours?	Start:	Stop:	
38. Describe your work schedule, include shift changes:			
39. List your sleeping hours during workdays:	Bedtime:		Get up:
40. List your sleeping hours during non-workdays:	Bedtime:		Get up:
41. After getting into bed, how long do you wait before turning out the lights?			
42. How long does it usually take you to fall asleep after turning out the lights?			
43. On average, how many times do you wake up during the night?			
44. On average, how many times do you get out of bed during the night?			
45. If you get up at night, what wakes you up or gets you up?			
46. Do you nap? (If NO, skip to # 51)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
47. How many days per week do you nap?			
48. How many times per day do you nap?			
49. How long are your naps?			
50. Do you find naps refreshing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
51. Do you have vivid dreams while you nap?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
52. Do you find yourself falling asleep when you don't intend to?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
53. Does daytime sleepiness interfere with:	Daily job performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	School?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Relationships/family time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Activities you enjoy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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54. Do you feel you have more problems concentrating recently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
55. Have you felt less interested in sex recently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
56. Do you feel more irritable lately?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
57. Do you ever fall asleep driving?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
58. Have you ever had a car accident or a "near miss" due to falling asleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
59. Please check next to any of the following that you experienced as a child or currently experience:	Bed wetting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Falling out of bed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Head banging	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Rocking yourself to sleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sleep terrors/nightmares	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Inability to sleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sleep walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sleep talking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
60. Does anyone in your family have a sleep disorder?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
61. If so, who is it and what kind of sleep disorder is it?			
62. Is your father alive?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
63. If not, what did he die of?			
64. Is your mother alive?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
65. If not, what did she die of?			

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

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in a car, for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch, without alcohol	
In a car, while stopped for a few minutes, in traffic	
TOTAL SCORE	

Date: _____

Please respond to the following statements by circling on number in each row:

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	A GOOD PART OF THE TIME	MOST OF THE TIME
I feel down hearted, blue and sad	1	2	3	4
Morning is when I feel the best	4	3	2	1
I have crying spells or feel like it	1	2	3	4
I have trouble sleeping through the night	1	2	3	4
I eat as much as I use to	4	3	2	1
I enjoy looking at, talking to and being with attractive women/men	4	3	2	1
I notice that I am losing weight	1	2	3	4
I have trouble with constipation	1	2	3	4
My heart beats faster than usual	1	2	3	4
I get tired for no reason	1	2	3	4
My mind is as clear as it use to be	4	3	2	1
I find it easy to do the things I use to	4	3	2	1
I am restless and can't keep still	1	2	3	4
I feel hopeful about the future	4	3	2	1
I am more irritable than usual	1	2	3	4
I find it easy to make decisions	4	3	2	1
I feel that I am useful and needed	4	3	2	1
My life is pretty full	4	3	2	1
I feel that others would be better off if I were dead	1	2	3	4
I still enjoy the things I used to	4	3	2	1
TOTALS BY COLUMN				
TOTAL SCORE				

Thank you for completing this questionnaire. For more information on sleep, visit us online at www.PARsleep.com.