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?		□ Yes	□ No
5. Have you ever had sleep testing before?		□ Yes	□ No
6. Are you using Oxygen?		□ Yes	□ No
7. Are you on: (circle one)	CPAP / BiPAP		
8. Do you snore?		□ Yes	□ No
9. Do you stop breathing while asleep?		□ Yes	□ No
10. Do you wake up choking or gasping for air?		□ Yes	□ No
11. When you wake up in the morning, do you have:	Headaches?	□ Yes	□ No
	Dry Mouth?	□ Yes	□ No
	Sore throat?	□ Yes	□ No
	Confusion or Lethargy?	□ Yes	□ No
	Low Mood?	□ Yes	□ 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?	□ Frequently	□ Sometimes	□ Rarely
14. How restless is your sleep?	□ Extremely	□ Somewhat	□ Not at all
15. Is your sleep disturbed by:	Coughing?	□ Yes	□ No
	Nasal Congestion?	□ Yes	□ No
	Heartburn/reflux?	□ Yes	□ No
	Acting out dreams?	□ Yes	□ No
	Talking in your sleep?	□ Yes	□ No
	Walking in your sleep?	□ Yes	□ No
	Pain?	□ Yes	□ No
16. Do you have a bed partner?		□ Yes	□ No
17. Do you have pets that sleep in your bed?		□ Yes	□ No
18. Are you bothered by movements or snoring of others in your bed or in your room?		□ Yes	□ No
19. Do you leave the television on all night?		□ Yes	□ No
20. Is your bedroom dark and quiet at nights?		□ Yes	□ No
21. Do you eat or read in bed?		□ Yes	□ No
22. Have you been diagnosed with a seizure disorder?		□ Yes	□ No
23. Does your bed partner tell you that you kick or jerk your legs (or your arms) frequently when you are asleep?		□ Yes	□ 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)		□ Yes	□ No

Date:_____

25. Do the sensations and urge to move bother you more in the evening and at night rather than during the day?			□ Yes	□ No
26. Do other family members experience these same symptoms?			□ Yes	□ No
27. Do you have involuntary leg jerks when you are awake?			□ Yes	□ No
28. Do you often have trouble falling asleep or staying asleep?			□ Yes	□ 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 30.			□ Yes	□ No
31. Have you ever suddenly fallen to the ground without losing consciousness or fainting?			□ Yes	□ 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?			□ Yes	□ 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?			□ Yes	□ No
34. Do you wake up too early in the morning, unable to return to sleep?			□ Yes	□ No
35. How do you ordinarily awaken?	□ Spontaneously		□ Alarm Clock	□ 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)			□ Yes	□ 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?			□ Yes	□ No
51. Do you have vivid dreams while you nap?			□ Yes	□ No
52. Do you find yourself falling asleep when you don't intend to?			□ Yes	□ No
53. Does daytime sleepiness interfere with:	Daily job performance?		□ Yes	□ No
	School?		□ Yes	□ No
	Relationships/family time?		□ Yes	□ No
	Activities you enjoy?		□ Yes	□ No

Date:_____

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

Situation	**Chance of Dozing**
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.