Sleep Questionnaire

Name _____ Height _____ Weight _____

1. What is the MAIN reason for this test? _____
2. How long have you had this problem and what has been done for it so far?
   _____
3. Occupation: _____ Work times: _____ to _____
4. For women: Are you pregnant? Yes No If yes, how many weeks? _____
5. Use of oxygen: None Day Night Day & Night Oxygen Rate _____ lpm
6. Chronic opiate/pain medication use: Yes No
7. Number of sleep hours per day _____
8. Number of naps per week _____
9. Number of awakenings per night _____
10. List sleeping pills used in past 3 months _____
11. Typical bedtime_____ Typical awake time _____
12. Average hours of sleep per day _____ Number of times to urinate _____

Associated Conditions
Circle all that apply:

Arrhythmias	Seizure disorder	Hypothyroidism	Diabetes
Congestive heart failure	Multiple Sclerosis	TMJ	Bipolar Disorder
Heart disease	Fibromyalgia, arthritis	Narcolepsy	Allergies
Heart attack	Depression	Nasal polyps	Bruxism
Stroke	Substance abuse	Grave's Disease	Hypertension
Water retention	Hiatal hernia/GERD	Dementia	Restless Legs
Chronic fatigue syndrome	Asthma	Bronchitis	Barrett's Syndrome
History of head injury/trauma	Deviated septum	Emphysema	Other:
Parkinson's Disease	Chronic sinus problems	Enuresis	

	Yes/No		Yes/No
Shift work or work at night	_____	Irregular sleep times	_____
Naps are refreshing	_____	Frequently use sleeping pills (incl OTC)	_____
Use of alcohol to sleep	_____	Drink caffeine 6 hrs prior to bed	_____
Eat chocolate 6 hrs prior to bed	_____	Watch TV or computer 2 hrs prior to bed	_____
Exercise more than 2 hrs prior to bed	_____	Daytime fatigue	_____
Difficulty falling asleep	_____	Memory is worse than usual	_____
Difficulty staying asleep	_____	Job difficulties due to sleepiness	_____
Frequent snoring/Partner states snoring	_____	Difficulty concentrating due drowsiness	_____
Difficulty breathing during sleep	_____	Difficulty staying awake when working	_____
Wakes due to gasping/snorting	_____	Difficulty staying awake when driving	_____
Sleep with head elevated/in a recliner	_____	Auto driving close calls from sleepiness	_____
Vivid dreams/frequent nightmares	_____	Auto driving accidents from sleepiness	_____
Difficulty waking up	_____	At risk occupation (truck driver/bus driver)	_____
Nonrestorative sleep/not feeling rested	_____	Feel need to nap during the day	_____
Sleepwalking/complex behavior during sleep	_____	Have stress or anxiousness at bedtime	_____
Frequent leg movements during sleep	_____	Frequent morning headaches	_____
Grind teeth during sleep	_____	Muscle weakness when excited	_____
Frequent nightmares	_____	Sleep Paralysis (can't move when wakening)	_____
		Aches, cramps or uncomfortable legs before sleep	_____

The Epworth Sleepiness Scale

0 = NEVER doze
1 = slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place like a theater or meeting	_____
As a passenger in a car for one hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car stopped for a few minutes in traffic	_____
TOTAL	_____