CNMRI Sleep Disorders Center

Sleep Questionnaire

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Patient Name: ___________________________ Date: ________________

Height: _____ Weight: _____ Neck Size: _____ Birthdate: ___________

1. Do you currently have a problem with sleep or wakefulness? ☐ Yes ☐ No (*skip to question 9*)

2. What type of problem (or problems) do you have? *Check as many as apply*.

- ☐ Snoring while asleep
- ☐ Stop breathing while asleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Early awakening; unable to fall back asleep
- ☐ Excessively long sleep at night
- ☐ Excessive sleepiness during waking hours
- ☐ Difficulty sleeping; waking at the desired times
- ☐ Unusual behavior or experiences during sleep (for example, nightmares or sleepwalking).
- ☐ Other:____

3. Overall, how severe is your sleep problem(s)?

☐ Slight ☐ Moderate ☐ Severe ☐ Very severe

4. How long have you had this problem?

☐ 1 month or less ☐ 1 to 6 months ☐ 6 to 12 months ☐ More than 1 year

5. Please describe what may have caused the problem(s) when it first began?

____

____

6. Would you say the problem(s) has been:

☐ Getting worse ☐ Staying the same ☐ Getting better ☐ Variable

7. How often does the problem(s) occur:

☐ Daily or every night ☐ Few times weekly ☐ Few times monthly ☐ Variable

8. Has the problem(s) interfered with your ability to function at home, work or with other people?

☐ Not at all ☐ Slightly ☐ Moderate ☐ Severely

9. Do you sleep in the same place each night?

☐ Yes ☐ No If no, where do you sleep? ____________________________________

10. Is your sleeping place comfortable in terms of temperature, light, sound and bedding?

☐ Yes ☐ No If no, how is it uncomfortable? _________________________________

11. Do you have a bedtime "routine" (snacks, exercise, showering, etc)?

☐ Yes ☐ No If yes, please describe: ______________________________________

12. If you are away from home, how do you usually sleep compared to home?

☐ Worse than usual ☐ About the same ☐ Little better ☐ Much Better

13. How sleepy do you usually feel when you go to bed?

☐ Not at all sleepy ☐ Slightly sleepy ☐ Moderate sleepy ☐ Very sleepy

14. Are your sleeping hours usually constant from day to day?

☐ Yes ☐ No Please describe: ____

15. What is the usual time you go to bed? __________________ ☐ PM ☐ AM

16. What is the usual time you try to go to sleep? ____________ ☐ PM ☐ AM

17. How long does it usually take you to fall asleep? ____________ ☐ Minutes ☐ Hours

18. How many times do you usually wake up during the night? _________________________________

19. If you awaken, how long does it usually take you to fall back asleep? ________________________

20. At what time do you usually awaken for good? ______________ ☐ PM ☐ AM

21. Accounting for any awakenings, how long do you actually sleep? ________________________

22. At what time do you actually get out of bed to start your day? ____________ ☐ PM ☐ AM

23. Do you work outside of the home? ☐ Day Shift ☐ Night shift ☐ Alternating shift

Please describe: ____

24. Do you frequently travel across time zones? ☐ Yes ☐ No

Please describe: ____

25. Have you ever used medication to help you sleep? ☐ Yes ☐ No

Please describe: ____

26. Have you ever used medication to keep you awake during the day? ☐ Yes ☐ No

Please describe: ____

27. Do any of the following occur at bedtime or during your sleep? *Check as many as appropriate.*

- ☐ Restless, uncomfortable legs in the evening
- ☐ Feeling anxious, tense or worrying at bedtime
- ☐ Large body jerks as you are falling asleep
- ☐ Jerking or twitching in feet, legs, arms or buddy
- ☐ Palpitations, heart racing, irregular heart beat
- ☐ Difficulty breathing (including wheezing)
- ☐ Frequent coughing
- ☐ Awaken choking, smothering or gasping for air
- ☐ Heartburn or other burning in chest, stomach
- ☐ Grinding teeth
- ☐ Need to urinate
- ☐ Incontinence (wetting the bed)
- ☐ Frequent tossing and turning
- ☐ Leg cramps
- ☐ Talking or screaming in your sleep
- ☐ Screaming in your sleep
- ☐ Sleepwalking
- ☐ "Acting out" dreams
- ☐ Kicking, punching or swinging during sleep
- ☐ Rocking movements before or during sleep
- ☐ Eating during sleep
- ☐ Awakening with feelings of panic or terror
- ☐ Nightmares
- ☐ Awakened by dreams (not nightmares)
- ☐ Seizures
- ☐ Confusion during sleep or upon awakening
- ☐ Headaches beginning during sleep
- ☐ Other pain during sleep
- ☐ Awakened by noises, light, children
- ☐ Feeling too hot or too cold
- ☐ Awakened by partner's movements or sounds
- ☐ Awakened for no reason
- ☐ Hallucinations as you are falling asleep or waking up. For example, seeing or hearing things which turn out not to actually be real.
- ☐ Feeling paralyzed as you are falling asleep

Describe other sleep disturbance:____

____

28. Do you have any difficulty awakening and becoming alert in the morning? ☐ Yes ☐ No

29. How do you typically feel when you awaken? *Check as many as appropriate*.

☐ Alert ☐ Sleepy ☐ Energetic ☐ Low Energy ☐ Irritable

☐ Optimistic ☐ Depressed ☐ Confused ☐ Refreshed ☐ Anxious

30. How sleepy do you usually feel during the daytime? *"Sleepy" means able to or actually falling asleep*.

☐ Not at all ☐ Slightly ☐ Moderate ☐ Extremely

31. Do you ever fall asleep unintentionally during the day OR take any daytime naps?

☐ Yes ☐ No (*Skip to Question 37*) ☐ Fall asleep unintentionally ☐ Take daytime naps

32. How often do you fall asleep or nap during the day?

☐ Infrequently ☐ Few times weekly ☐ Once or twice a day ☐ 3 or more times a day

33. When you fall asleep or nap, how long do you usually remain asleep?

☐ 5 minutes or less ☐ 5 to 30 minutes ☐ 30 to 60 minutes ☐ Over one hour

34. At what time(s) do you usually fall asleep or take a nap? ____________ ☐ PM ☐ AM

35. Do you dream when you fall asleep or nap?

☐ Never ☐ Occasionally ☐ Frequently ☐ Always

36. Do you feel more alert and awake after falling asleep or napping? ☐ Yes ☐ No

37. Have you ever had an accident because of sleepiness or falling asleep? ☐ Yes ☐ No

38. How fatigued do you feel during the day? *"Fatigue" refers to a feeling of tiredness in your muscles or body, rather than actual sleepiness*.

☐ Never ☐ Occasionally ☐ Frequently ☐ Always

39. Do any aspects of your daytime activities suffer due to nighttime sleep disturbances, daytime sleepiness or fatigue? ☐ Yes ☐ No

Describe:____

40. When during the day do you function best?

☐ Early morning ☐ Late morning ☐ Early afternoon ☐ Late afternoon

☐ Early evening ☐ Late evening ☐ Night ☐ No particular time

41. Have you ever had sudden attacks of muscle weakness so that you slumped or fell unexpectedly?

☐ Yes ☐ No If yes, describe:____

42. Indicate your current prescription and over-the-counter medications below (*attach list in need be*):

Medication	Dose	Time(s) of day
______________________________	_____________	____________________
______________________________	_____________	____________________
______________________________	_____________	____________________
______________________________	_____________	____________________
______________________________	_____________	____________________

43. Do you have any known allergies? ☐ Yes ☐ No
If yes, describe:____

44. If you use alcohol? Type and Amount: ___________ ☐ Daily ☐ Weekly ☐ Monthly

45. Caffeinated beverages? ☐ Coffee ☐ Tea ☐ Soda Amount: __________________

46. Do you use cigarettes or other tobacco products? ☐ Yes ☐ No Amount: __________

47. Are you on a specific diet? ☐ Yes ☐ No Describe: _____________________________

48. Do you exercise on a regular basis?? ☐ Yes ☐ No Describe: __________________

49. Did you have any of the following sleep problems as a child or adolescent? Indicate age.

☐ Insomnia ☐ Sleepwalking ☐ Talking in your sleep ☐ Bed-wetting
☐ Nightmares ☐ Night terrors ☐ Head-banging ☐ body rocking
☐ Nocturnal Seizures ☐ Daytime sleepiness ☐ Breathing difficulties ☐ Other

Describe and indicate age:____

50. Describe any current or past medical problems below:

____
____
____

51. List any past surgeries below:

____
____
____

52. Describe current or past psychiatric or nervous problems (depression, anxiety, panic attacks, treatment or evaluation by psychiatrist, psychologist, or therapist).

____

____

53. Describe any current or past problems with alcohol, drug or substance abuse or addiction:

____

____

54. Do any relatives or family member(s) have a sleep-related problem? ☐ Yes ☐ No
Please describe: ____

55. If there is any additional information which you think would be important for evaluating your sleep or sleep-related problems, please describe below:

____

____

If anyone helped you fill out this questionnaire, please indicate below:

Name:_______________________________________ Relation:____________________

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to 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 = no chance of dozing; 1 = slight chance dozing 2 = moderate chance dozing 3 = high chance dozing

Situation	**Chance of Dozing (0 to 3 scale)**			
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in a public place (eg: movie theatre, meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: ____________ (If greater than 9, neurology evaluation for sleep apnea suggested.)