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SLEEP QUESTIONNAIRE

Name:	Profession:	Sex:
Birth date: Age:	Birthplace:	
Referring physician:	Telephone:	
Primary physician:	Telephone:	
Today's date:		
Chief complaint:		
When did your sleep problem begin?		
Is this the first time you consult a sleep specialist? **Yes** **No** If no, when and whom did you consult?		

Briefly explain your sleep problem.

Circle the appropriate size of your bed? **King** **Queen** **Full** **Twin**

Do noises regularly keep you from sleeping well? **Yes** **No**

Do lights regularly keep you from sleeping well? **Yes** **No**

Does room temperature keep you from sleeping well? **Yes** **No**

Please enter the usual time that you:

	Workdays	**Days off**
What time do you go to bed at night?		
How fast do you fall asleep?		
How many times wake up in the middle of the night?		
For how long are you awake in the middle of the night?		
What time do you wake up in the morning?		
Do you take a nap?		
How many hours per day?		
How many days per week?		

Please circle the most appropriate response to the following questions. Please describe the **typical** experience over the period of time since developing your sleep problem.

1. Does it usually take you more than 30 minutes to fall asleep?	**Yes**	**No**
2. Do you usually have trouble sustaining sleep?	**Yes**	**No**
3. Do you wake up prematurely and find it difficult to resume sleep?	**Yes**	**No**
4. Do you snore regularly?	**Yes**	**No**
5. Does your snoring disturb others?	**Yes**	**No**
6. Do you have awakenings because of choking?	**Yes**	**No**
7. Do you have awakenings because of shortness of breath?	**Yes**	**No**
8. Do you wake up with headaches?	**Yes**	**No**
9. Does napping and/or longer sleep make you feel better?	**Yes**	**No**
10. Do you dream during naps?	**Yes**	**No**
11. Do dreams interfere with your sleep?	**Yes**	**No**
12. Have you ever experienced muscle weakness in any part of the body:		
a. After telling and/or hearing a joke?	**Yes**	**No**
b. After a hardy laugh?	**Yes**	**No**
c. After becoming angry?	**Yes**	**No**
13. When awakening, have you found yourself briefly unable to move?	**Yes**	**No**
14. Have you experienced dreaming while awake?	**Yes**	**No**
15. Do your legs bother you when trying to sleep?	**Yes**	**No**
16. Do you sleep talk?	**Yes**	**No**
17. Are you now or have you been a sleepwalker?	**Yes**	**No**
18. Have you hurt yourself during your sleep?	**Yes**	**No**
19. Have your movements while asleep hurt others?	**Yes**	**No**
20. Does heartburn interfere with your sleep?	**Yes**	**No**
21. Does the need to urinate regularly interrupt your sleep?	**Yes**	**No**
22. Did you see a psychologist or psychiatrist for your sleep problem?	**Yes**	**No**

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to 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	**Number**
Sitting and reading	
Watching television	
Sitting, inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an 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, while stopped for a few minutes in traffic	
Total number	