

Noran Clinic Sleep Center

Sleep Questionnaire

Name: _____ Date of Birth: _____

In order to serve you better, we have designed a questionnaire regarding aspects of your 'sleep'. Please complete the following questionnaire and **bring it with you at the time of your appointment.**

Today's Date: _____

Primary Doctor: _____

Referring Doctor: _____

1. In your own words, please describe your main problem regarding sleep.

a. How long has the problem bothered you? _____

b. How often does this problem occur? _____

c. Please estimate the severity of the problem based on a scale of 1 to 5, with **5 being the most severe.**

1 2 3 4 5

2. How would you describe your sleep problem? (*check all that apply*)

- Difficulty falling asleep
- Wake up during the night
- Wake up early in the morning
- Excessive daytime sleepiness
- Difficultly awakening

3. Using the Epworth Sleepiness Scale below, please rate the following questions:

Epworth Sleepiness Scale

- 0 – **Never** doze
- 1 – **Slight** chance of dozing
- 2 – **Moderate** chance of dozing
- 3 – **High** chance of dozing

Situation

- a. Sitting and reading
- b. Watching TV
- c. Sitting inactive in a public place (theatre, movie, etc.)
- d. As a passenger in a car for an hour without a break
- e. Lying down to rest in the afternoon when circumstances permit
- f. Sitting and talking with someone
- g. Sitting quietly after lunch with alcohol
- h. In a car, while stopped for a few minutes in traffic

Chance of Dozing

Total: _____

Name: _____

Date of Birth: _____

4. Do any of your family members have sleep problems? **Yes No**

If yes, please explain: _____

5. What treatment, if any, have you had for your sleep problem?

6. Have you had previous sleep studies? **Yes No**

If yes, when, where, and what were the results: _____

7. Please circle **Yes** or **No** to the following questions:

- | | | |
|--|------------|-----------|
| • Awaken from sleep short of breath | Yes | No |
| • Awaken at night with heartburn, belching or cough | Yes | No |
| • Snore | Yes | No |
| • Snore loudly enough that others complain | Yes | No |
| • Have trouble sleeping when you have a cold | Yes | No |
| • Suddenly wake up gasping for breath during the night | Yes | No |
| • Having breathing problems at night (observed by self or others) | Yes | No |
| • Sweat excessively at night | Yes | No |
| • Notice your heart pounding/beating irregularly during the night | Yes | No |
| • Fall asleep during the day | Yes | No |
| • Fall asleep involuntarily | Yes | No |
| • Fall asleep while driving | Yes | No |
| • Fall asleep during physical effort | Yes | No |
| • Fall asleep while laughing or crying | Yes | No |
| • Experience loss of muscle tone when extremely emotional | Yes | No |
| • Have trouble at work or school because of sleepiness | Yes | No |
| • Feel unable to move (paralyzed) when waking or falling asleep | Yes | No |
| • Experience vivid dreamlike scenes upon awakening or falling asleep | Yes | No |
| • Feel afraid of going to sleep | Yes | No |
| • Have nightmares | Yes | No |
| • Remember your dreams | Yes | No |
| • Have thoughts racing through your mind | Yes | No |
| • Feel sad or depressed | Yes | No |
| • Have anxiety (worry about things) | Yes | No |
| • Have muscle tension | Yes | No |
| • Notice parts of your body jerk | Yes | No |
| • Kick during the night | Yes | No |
| • Experience crawling or aching during the night | Yes | No |
| • Experience any type of leg pain at night | Yes | No |
| • Have morning jaw pain | Yes | No |
| • Grind teeth during sleep | Yes | No |
| • Are bothered by pain during the day | Yes | No |
| • Wake up feeling stiff in the morning | Yes | No |
| • Wake up with sore or achy muscles | Yes | No |
| • Wake up with pain in the neck, spine or joints | Yes | No |

8. How many hours of sleep do you usually get each night? _____

9. What time do you usually go to bed? _____

10. Do you take medications to fall asleep? **Yes No**

If yes, please list: _____

Name: _____

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11. How long does it take you to fall asleep? _____

12. How many times do you wake at night? _____

13. What time do you awaken in the morning? _____

14. Are your sleep habits different on the weekends? **Yes No**

If yes, please describe: _____

15. Do you work split shifts or rotating shifts? **Yes No**

If yes, please describe: _____

16. Do you drink coffee, tea and/or soda (caffeine) within two hours of going to bed? **Yes No**

17. Do you read before falling asleep? **Yes No**

18. Do you watch TV in bed before falling asleep? **Yes No**

19. Do you take naps during the day? **Yes No** If yes, how many? _____ Duration? _____

20. Do you feel refreshed after a night's sleep? **Yes No**

21. Do you drink alcohol? **Yes No** If yes, how many drinks per day/week? _____

22. Have you gained weight recently? **Yes No** If yes, how much? _____

In what time period (weeks, months, etc.)? _____

23. Do you have morning headaches? **Yes No**

24. Do you frequently have a depressed mood? **Yes No**

25. Are you working? **Yes No**

26. Briefly describe the best job you have ever had: _____

27. Please provide any additional information you feel is pertinent to your sleepiness or wakefulness:

28. Please list all medications: _____

29. Please list all past medical problems: _____
