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
   - Difficulty 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**       **Chance of Dozing**
   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       ________

   **Total: ________**
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: ________________________________________________________________
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: