Noran Neurology 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. 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
   - ☐ Other

2. 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

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 without alcohol	_____
h. In a car, while stopped for a few minutes in traffic	_____
Total:	_____

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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 or headaches	**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: _____

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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 take naps during the day? **Yes** **No** If yes, how many? _____ Duration? _____
16. Do you feel refreshed after a night's sleep? **Yes** **No**
17. Do you work split shifts or rotating shifts? **Yes** **No**

    If yes, please describe: _____
18. Do you drink coffee, tea and/or soda (caffeine) within two hours of going to bed? **Yes** **No**

    a. how many cans/cups per day?_____

    b. when is your last drink of caffeinated beverage on a typical day? _____
19. Do you read before falling asleep? **Yes** **No**
20. Do you watch TV in bed before falling asleep? **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: _____

    _____