SLEEP RITE
SLEEP QUESTIONNAIRE

Patient Name: _____ DOB: _____Sex: **M / F** Age: ___Date:_____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night How many months/years? _____

❑ Being sleepy all day How many months/years? _____

❑ Snoring How many months/years? _____

❑ Unwanted behaviors during sleep, explain _____

❑ Other, explain _____

Sleep Pattern	Work Days (Weekday)	Off Days(Weekends)
Typical bedtime:	_____ a.m./p.m.	_____a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____a.m./p.m.
How do you usually awaken, i.e., alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____a.m./p.m.
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

Name: _____Check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Name: _____

Habits

Do you smoke? ❑ Yes ❑ No

If Yes:	What?	Amount per Day	For How Many Years
	❑Cigarettes	_____ pack(s)	_____ years
	❑Cigars	_____ cigars	_____ years
	❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes:	What?	Frequency		AmountperWeek
	❑Beer	❑Daily	❑Weekends	❑Rare _____cans/week
	❑Wine	❑Daily	❑Weekends	❑Rare _____glasses/week
	❑Liquor	❑Daily	❑Weekends	❑Rare _____shots/week

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status: ❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker
- ❑ I am currently a student

Medical History

What is your: Height? ____ feet _____inches Weight? _____ pounds NeckSize:_____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Current Medications

Medication	Dose	Times per Day

Allergies:

_____

Name: _____

Past Sleep Evaluation and Treatment

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

Past Medical History

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Cancer
- ❑ Thyroid problems
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems
- ❑ Erectile dysfunction/impotence

List other past medical problems and dates:

_____ _____

_____ _____

_____ _____

List Surgeries and the year

_____ _____

_____ _____

_____ _____

Name: _____

Check any of the following symptoms you have had in the past 12 months:

Yes	No		Yes	No	
❑	❑	Frequent headaches	❑	❑	Frequent heartburn / indigestion
❑	❑	Fainting or passing out	❑	❑	Abdominal pain
❑	❑	Sudden loss of vision or strength	❑	❑	Frequent constipation
❑	❑	Inability to speak	❑	❑	Frequent diarrhea
❑	❑	Hearing loss or ringing in ear(s)	❑	❑	Rectal bleeding / black stools
❑	❑	Hoarseness for more than 2-4 weeks	❑	❑	Difficulty urinating /incontinence
❑	❑	Nosebleeds	❑	❑	Blood in urine
❑	❑	Cough for more than 2-4 weeks	❑	❑	Urinating more than twice a night
❑	❑	Coughing up blood	❑	❑	Pain in joints or bones
❑	❑	Shortness of breath or wheezing	❑	❑	Unusual bruising or bleeding
❑	❑	Swelling in feet or ankles	❑	❑	Epilepsy / seizures
❑	❑	Chest pain, tightness or pressure	❑	❑	Change in wart, mole,skin growth
❑	❑	Irregular or sudden, fast heartbeat	❑	❑	Weight loss of more than 5-10lbs
❑	❑	Difficulty swallowing or food "sticking"			

Family History

Has an immediate blood relative had any of the following?

Yes	No		Relation
❑	❑	Cancer	_____
❑	❑	Diabetes	_____
❑	❑	Hypertension	_____
❑	❑	Heart disease	_____
❑	❑	Thyroid disease	_____
❑	❑	Stroke	_____
❑	❑	Anxiety/Depression	_____
❑	❑	Sleep Apnea	_____
❑	❑	Narcolepsy	_____
❑	❑	Other:	_____

Name: _____

Using the Answer Key below, please circle the number that best applies to your life over the past 6 months.

Answer Key **1** – Never (Strongly disagree) **2**- Rarely (Disagree) **3** – Sometimes (Not sure) **4** – Usually (Agree) **5** – Always (Agree strongly)

I have trouble falling asleep	1	2	3	4	5
I wake up often during the night	1	2	3	4	5
At bedtime, thoughts race through my mind	1	2	3	4	5
At bedtime, I feel sad and depressed	1	2	3	4	5
When falling asleep, I feel paralyzed (unable to move)	1	2	3	4	5
When falling asleep, I have restless legs (creepy-crawly feelings, aching, or inability to keep legs still)	1	2	3	4	5
If I wake up during the night, I have trouble getting back to sleep because of restless legs or leg movements	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breathe	1	2	3	4	5
At night my heart pounds, beats rapidly, or beats irregularly	1	2	3	4	5
I sweat a great deal at night	1	2	3	4	5
My sleep is disturbed by sadness or depression	1	2	3	4	5
I have a lot of nightmares (frightening dreams)	1	2	3	4	5
I feel unable to move (paralyzed) after a nap	1	2	3	4	5
I have dream-like images (hallucinations) as I wake up in the morning, even though I know I am not asleep	1	2	3	4	5
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	1	2	3	4	5
I have been unable to sleep at all for several days	1	2	3	4	5
I feel that I have insomnia	1	2	3	4	5
I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
I got bad grades in school because I was too sleepy	1	2	3	4	5

Name: _____

Answer Key **1** – Never (Strongly disagree) **2**- Rarely (Disagree) **3** – Sometimes (Not sure) **4** – Usually (Agree) **5** – Always (Agree strongly)

In the past 6 months I have fallen asleep while eating, talking to someone, riding in a bus or car, reading a book, watching TV or a movie, or listening to a lecture	1	2	3	4	5
I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
I often have to let someone else drive the car because I am too sleepy to drive	1	2	3	4	5
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	1	2	3	4	5
I often am unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it	1	2	3	4	5
I get "weak knees" when I laugh	1	2	3	4	5
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion	1	2	3	4	5
I have high blood pressure (or once had it)	1	2	3	4	5
My desire or interest in sex is less than what it used to be	1	2	3	4	5
I am unhappy about loving relationships in my life	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
I smoke tobacco within two hours before bedtime	1	2	3	4	5
I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	1	2	3	4	5
My snoring or my breathing problem is worse if I sleep on my back	1	2	3	4	5
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	1	2	3	4	5