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SLEEP QUESTIONNAIRE

Name: ______________________ Date: ________ Completed by: Patient or ______________

Date of Birth: ______________________ Weight: ________ Height: __________

Referring physician: ______________________________

Current Medications: ____
____
____

Do you have any of the following: ☐ Snoring ☐ Daytime sleepiness ☐ Apnea (stop breathing)

Briefly describe your sleep problem: ____
____

When did your sleep problems begin? ______________________________

When did your sleep problems get worse? ___ days ago / ___ months ago / ___ years ago
(number) *(number)* *(number)*

Have you had a recent weight gain? ☐ No ☐ Yes, **how much?** ______________

Have you had prior sleep study? ☐ No
☐ Yes, When __________ Diagnosis: ______________

Have you had prior ENT surgery? ☐ No ☐ Yes, Where? nose, jaw, or throat ______________

Have you ever been treated for sleep apnea with a CPAP/BiPAP? ☐ No ☐ Yes
If yes, please mark current symptoms: ☐ Snoring ☐ Daytime sleepiness ☐ Apnea (stop breathing)

MAJOR SLEEP SYMPTOMS:

SELECT "YES" ONLY WHEN FREQUENTLY AND SIGNIFICANTLY
SELECT "NO" WHEN INFREQUENTLY AND INSIGNIFICANTLY

I snore in my sleep.
☐ No ☐ Yes

I am told I snore so loudly that it bothers others.
☐ No ☐ Yes

I wake up feeling short of breath (choking) or I stop breathing (hold my breath) in my sleep.
☐ No ☐ Yes

My snoring or breathing problem is much worse if I sleep on my back.
☐ No ☐ Yes

My snoring or breathing problem is much worse if I fall asleep right after drinking alcohol.
☐ No ☐ Yes

My snoring or breathing problem is much worse when I have an allergy or infection in the nose, throat or chest.

☐ No ☐ Yes

My legs jerk or kick throughout the night.

☐ No ☐ Yes

The quality of my sleep is poor.

☐ No ☐ Yes

My night sleep is restless and disturbed.

☐ No ☐ Yes

At night, my sleep disturbs my bed partner's sleep.

☐ No ☐ Yes

What time do you go to bed each night? ______________________________

How long does it take for you to go to sleep? ______________________________

My bedtime varies a lot.

☐ No ☐ Yes, due to work-shift, international flight, others: ____________________

I have trouble getting to sleep.

☐ No ☐ Yes, If so, do you sleep better away from home? ☐ No ☐ Yes

At bedtime, I feel tense and I worry about things.

☐ No ☐ Yes

At bedtime, I am afraid of not being able to go to sleep.

☐ No ☐ Yes

At bedtime, I use sleep aids.

☐ No ☐ Yes, please circle: sleeping pills, alcohol, melatonin, Others: ____________

How many times do you wake up at night? ______________________________

What wakes you up? ______________________________

____

My sleep is disturbed by severe heartburn, choking or acid reflux – "regurgitation" or bring up of bitter stomach fluid.

☐ No ☐ Yes

When I wake during the night, I feel I will be unable to get back to sleep.

☐ No ☐ Yes

I suddenly awaken gasping for air and unable to breathe.

☐ No ☐ Yes

What time do you get up each day on weekdays? ____________ **On weekends?** ____________

I feel refreshed upon awakening.

☐ No ☐ Yes

How many naps do you take per day and for how long? ______________________________

I am very sleepy in the daytime.

☐ No ☐ Yes, what time during the day ______________________________

I often fall asleep whenever I am not active (while driving, watching TV, in a meeting, etc.).

I drink a lot of caffeinated beverages to keep myself awake and alert.

☐ No ☐ Yes, What? Coffee, Tea, Coke, Others: ______________________________

OTHER SLEEP SYMPTOMS

SELECT "YES" ONLY WHEN FREQUENTLY AND SIGNIFICANTLY
SELECT "NO" WHEN INFREQUENTLY AND INSIGNIFICANTLY

I am often unable to move (paralyzed) when waking up from sleep (sleep paralysis).

☐ No ☐ Yes

I have dream-like vivid images (hallucinations) when I am falling asleep.

☐ No ☐ Yes

I have dream-like vivid images (hallucinations) when I awaken in the morning even though I know I am not asleep.

☐ No ☐ Yes

I get "weak knees" or "weak jaw" when I laugh (Cataplexy).

☐ No ☐ Yes

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 (Cataplexy).

☐ No ☐ Yes

I have vigorous violent behaviors that are accompanied by vivid dreams (acting out dreams).

☐ No ☐ Yes

When falling asleep, I have "restless legs" – which is a feeling of crawling, aching, or the inability to keep my legs still.

☐ No ☐ Yes

At night my heart pounds and / or beats rapidly or irregularly.

☐ No ☐ Yes

I sweat a great deal at night.

☐ No ☐ Yes

I grind my teeth while I sleep.

☐ No ☐ Yes

I walk in my sleep.

☐ No ☐ Yes

I talk in my sleep.
☐ No ☐ Yes

I wake up from sleep screaming, confused, and at times violent (night terrors)
☐ No ☐ Yes

I have a lot of frightening dreams (nightmares).
☐ No ☐ Yes

I have a chronic chest disease (bronchitis, asthma, emphysema).
☐ No ☐ Yes

I have a problem with my nose blocking up when I am trying to sleep (allergies, infections, nasal obstruction).
☐ No ☐ Yes

PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU:

☐ High blood pressure ☐ Heart Disease ☐ Thyroid Disorder
☐ COPD (emphysema/Bronchitis) ☐ Asthma ☐ Diabetes
☐ Stroke ☐ Anxiety ☐ Depression
☐ Kidney trouble ☐ Psychiatric problems: ______________________
☐ Neurological Disorders: (circle) Parkinson's Disease, Alzheimer's Disease
☐ Other Neurological Disorders: ____

☐ Low blood pressure ☐ Heart Attack ☐ Pacemaker
☐ Bypass Surgery ☐ High Cholesterol ☐ Obesity
☐ Heartburn ☐ GERD ☐ Ulcers
☐ Reflux ☐ Headaches ☐ Dizziness
☐ Fainting ☐ Allergies ☐ Sinus Problems
☐ Tonsillectomy ☐ Nose Fracture ☐ Nasal Surgery
☐ Eye trouble ☐ Hearing trouble ☐ Seizures
☐ Muscle cramps/weakness ☐ Arthritis ☐ Back Pain
☐ Hiatal Hernia ☐ Fibromyalgia ☐ Cancer
☐ Prostate trouble ☐ Impotence ☐ Meningitis
☐ Hemophilia (bleeder) ☐ Tuberculosis

EPWORTH SLEEPINESS SCALE

NAME: ____

Today's Date: ____________________ Your Age (years): ______________

Your gender (male = M; female = F): ______________________________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your 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	**Chance of dozing**
1. Sitting and reading.	________
2. Watching television.	________
3. Sitting inactive in a public place (i.e. theatre).	________
4. As a passenger in a car for an hour without a break.	________
5. Lying down to rest in the afternoon when circumstances permit.	________
6. Sitting and talking to someone.	________
7. Sitting quietly after lunch without alcohol.	________
8. In a car, while stopped for a few minutes in traffic.	________
Total score	________

Thank you for your cooperation.