Healthy Driven
Edward-Elmhurst HEALTH

PATIENT SLEEP QUESTIONNAIRE

Date: _____ **Patient Name:** _____ **Sex:** _____ **DOB:** _____

Height: _____ Current Weight: _____ Neck Size: _____

In your words, please describe your primary sleep complaint:

_____

_____

_____

_____

How long has the problem bothered you? _____

_____

How often does this problem occur? _____

_____

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

☐1 ☐2 ☐3 ☐4 ☐5

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

Do any of your family members have sleep problems? ☐Yes ☐No

If yes, please explain:

_____

_____

What treatment, if any, have you had for your sleep disorder?

_____

_____

Using the following scale:

N= Never **R**= Rarely **O**= Occasionally **F**= Frequently **C**= Constantly

Please rate how often you:

Awaken from sleep short of breath	**N**	**R**	**O**	**F**	**C**
Awaken at night with heartburn, belching or cough	**N**	**R**	**O**	**F**	**C**
Snore	**N**	**R**	**O**	**F**	**C**
Snore loudly enough that others complain	**N**	**R**	**O**	**F**	**C**
Have trouble sleeping when you have a cold	**N**	**R**	**O**	**F**	**C**
Suddenly wake up gasping for breath during the night	**N**	**R**	**O**	**F**	**C**
Having breathing problems at night (observed by self and others)	**N**	**R**	**O**	**F**	**C**
Sweat excessively at night	**N**	**R**	**O**	**F**	**C**
Notice your heart pounding /beating irregularly during the night	**N**	**R**	**O**	**F**	**C**
Fall asleep during the day	**N**	**R**	**O**	**F**	**C**
Fall asleep involuntarily	**N**	**R**	**O**	**F**	**C**
Fall asleep while driving	**N**	**R**	**O**	**F**	**C**
Fall asleep during physical effort	**N**	**R**	**O**	**F**	**C**
Fall asleep while laughing or crying	**N**	**R**	**O**	**F**	**C**
Experience loss of muscle tone when extremely emotional	**N**	**R**	**O**	**F**	**C**
Have trouble at work or school because of sleepiness	**N**	**R**	**O**	**F**	**C**
Feel unable to move (paralyzed) when waking or falling asleep	**N**	**R**	**O**	**F**	**C**
Experience vivid dreamlike scenes upon awakening or falling asleep	**N**	**R**	**O**	**F**	**C**
Feel afraid of going to sleep	**N**	**R**	**O**	**F**	**C**
Have nightmares	**N**	**R**	**O**	**F**	**C**
Remember your dreams	**N**	**R**	**O**	**F**	**C**
Have thoughts racing through your mind	**N**	**R**	**O**	**F**	**C**
Feel sad or depressed	**N**	**R**	**O**	**F**	**C**
Have anxiety (worry about things)	**N**	**R**	**O**	**F**	**C**
Have muscular tension	**N**	**R**	**O**	**F**	**C**
Notice parts of your body jerk	**N**	**R**	**O**	**F**	**C**
Kick during the night	**N**	**R**	**O**	**F**	**C**
Experience crawling and aching during the night	**N**	**R**	**O**	**F**	**C**
Experience any type of leg pain during the night	**N**	**R**	**O**	**F**	**C**
Have morning jaw pain	**N**	**R**	**O**	**F**	**C**
Grind teeth during sleep	**N**	**R**	**O**	**F**	**C**
Are bothered by pain during the day	**N**	**R**	**O**	**F**	**C**

Experience urges to move your limbs that is worse with inactivity or improves with movement	**N**	**R**	**O**	**F**	**C**
Experience urges to move your limbs occurring most often in the evening or at night when lying down	**N**	**R**	**O**	**F**	**C**
Wake up feeling stiff, sore achy muscles, neck, spine or joints	**N**	**R**	**O**	**F**	**C**

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

What time do you usually go to bed? _____

How long does it take to fall asleep? _____

How many times do you wake up at night? _____

What time do you awaken in the morning? _____

Is your sleep disturbed by?

☐Heat ☐Child
☐Cold ☐Light
☐Noise ☐Bed partner
☐Other: _____

Are your sleep habits different on the weekends? ☐Yes ☐No
If yes, please describe: _____
_____
_____

Do you work split shifts or rotating shifts? ☐Yes ☐No
If yes, please describe: _____
_____
_____

Do you drink coffee, tea and/or soda (caffeine) within 2 hours of going to bed?	☐Yes	☐No
Do you read before falling asleep?	☐Yes	☐No
Do you watch TV in bed before falling asleep?	☐Yes	☐No
Do you take naps during the day?	☐Yes	☐No
Do you feel refreshed after a night's sleep?	☐Yes	☐No

Do you drink alcohol? ☐Yes ☐No
Have you gained weight recently? ☐Yes ☐No
If yes, how much? _____
Do you have morning headaches? ☐Yes ☐No
Do you frequently have a depressed mood? ☐Yes ☐No

Epworth Scale

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 during the past week or two. Even if you have not done some of these things, estimate how likely you would be to doze off or fall asleep in these situations.

Use the following scale:

0= would *never*
1= *slight* chance of dozing
2= *moderate* chance of dozing
3= *high* chance of dozing

SITUATION	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

1. Please provide any additional information you feel is pertinent to your sleepiness or wakefulness:
   _____
   _____
   _____
2. Please list all medications: _____
   _____
   _____
   _____
3. Please list all past medical problems: _____
   _____
   _____
   _____

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BED PARTNER QUESTIONNAIRE

Patient Name: _____ Date: _____

Relationship to patient: _____

How often have you observed this person's sleep?

☐ **Never** ☐ **Once or Twice** ☐ **Often** ☐ **Every night**

Please describe in detail any sleep behaviors you have observed. Include a description of the activity, the time during the night when it occurs and how frequent it occurs

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What behaviors have you observed in this person while he or she is asleep? Check all that apply and write any other behaviors that do not appear on the list

BEHAVIOR FREQUENCY ***(N= NEVER, R= RARELY, O= OCCASIONALLY, F= FREQUENTLY, C = CONSTANTLY)***

_____ **Light snoring**	_____	_____ **Bedwetting**	_____
_____ **Loud snoring**	_____	_____ **Limb movements**	_____
_____ **Teeth grinding**	_____	_____ **Unusual activity**	_____
_____ **Leg or arm twitching**	_____	_____ **Other**	
_____ **Sitting up in bed**	_____	_____	
_____ **Awakening with pain**	_____		
_____ **Loud snorts**	_____		
_____ **Leg kicking**	_____		
_____ **Head rocking/banging**	_____		
_____ **Choking**	_____		
_____ **Shaking or rocking**	_____		
_____ **Sleepwalking**	_____		
_____ **Pauses in breathing**	_____		
_____ **Becoming very rigid**	_____		