SLEEP DISORDERS QUESTIONNAIRE

1. Patient Name: ____ Date: ___________________

2. Briefly describe your sleep problem. (If you have no sleep problem, please indicate why you were referred).
   ____
   ____
   ____

3. At what age did this problem begin? __________ years of age.
4. How does this affect your life and daily activities?
   ____
   ____
   ____
5. How serious is this problem for you? (Please indicate a vertical mark on the line below to indicate you answer).

Very serious ______________________________________ _____________________Not at all serious

6. Have you had any previous evaluations, examinations, or treatments for this sleep problem or any other problem with your sleep? Yes _____ No _____

If yes, briefly describe the evaluation, treatment and results.
____
____
____

7. Have you used any medication (prescribed or otherwise) to help your sleep problem?
   Yes ________ No ________

If yes, list below

Name	Amount	Frequency	How long Used?	How Useful?	Physician

8. For each of the beverages listed, write in the average number you drink each day

Natural coffee _____ cups/day
Decaffeinated Coffee _____cups/day
Tea _____cups/day
Carbonated soft drinks _____cups/day

9. If employed, what is your usual work schedule?
Start _____am/pm
Stop _____am/pm

Do your work shifts change? _____Never _____Infrequently _____Regularly

10. What time do you usually go to bed and get up on *weekdays*?

Go to bed _____am/pm
Get up _______am/pm

What time do you usually go to bed and get up on the *weekends*?

Go to bed _____am/pm
Get up _____am/pm

On the average, how long does it take you to fall asleep at night after you turn off bedroom lights? _____ minutes

What do you ordinarily do just prior to turning out the lights and attempting to go to sleep? (e.g. read, watch T.V., bathe, etc)

____

____

On the average, how often do you wake up during the night?
_______times

11. On the average how long are you actually asleep at night?
_______hrs______min

How do you ordinarily awaken?
Spontaneously_________ Alarm Clock________ Other_________________________

How difficult is it for you to awaken and get out of bed after sleeping?
Very Difficult_______ Difficult______ Sometimes Difficult_______ No problem______

How long does it take you to be alert and functioning after sleeping?
________minutes

12. Are you bothered by sleeping during the day?
    Yes_______ No______

    Do you usually feel tired during the day?
    Yes_______ No______
    If yes, what do you attribute this to?____

    Do you feel you get too much sleep at night?
    Yes_______ No______

    Do you feel you get too little sleep at night?
    Yes_______ No______

    Have you been told you snore while asleep?

    Yes_______ No______
    If yes, does the snoring disturb…
    a) a bed partner or someone in the same room?
       Yes_______ No______

    b) someone in the next room?
       Yes_______ No______

13. Do you find yourself falling asleep when you do not want to?
    Yes_______ No______
    If yes, describe:____

    ____

    How long does the sleep episode last?
    _______hrs ______ mins

    Do you feel rested or refreshed after the sleep episode?
    Yes_______ No______

    Do you nap?
    Yes_______ No______
    If yes, how many times per day _______. Average length of nap _____hrs______mins

14. Do you wake up too early in the morning and re then unable to return to sleep?
    Yes_______ No______

15. Have you ever:
    a. Suddenly fallen?
       Yes_______ No______
    b. Experienced sudden bodily weakness?
       Yes_______ No______
    If yes, to either of above, were you aware of the things around you?
    Yes_______ No______

Was the fall or weakness brought on by any particular even or feeling (anger, sadness, laughing)

Yes______ No_____

If yes, briefly describe:____

____

16. Have you ever experienced weakness or paralysis upon:
    a. going to sleep

       Yes______ No_____

    b. awakening from sleep

       Yes______ No_____

How often does this occur?

______times per week

17. Have you ever experienced seeing things and/or hearing voices or noises that were not real:
    a. upon going to sleep?
       Yes______ No_____
    b. during the night?
       Yes______ No_____
    c. upon wakening from sleep?
       Yes______ No_____
    d. during the day?
       Yes______ No_____

18. Do you have difficulty breathing at night?

Yes______ No_____

If yes, briefly describe:____

____

How often? _____times a night. When did this first occur? _____years of age

How did you become aware of this?____

____

19. Have you ever experienced upon lying in bed before sleep or upon awakening sleep:

restless of legs_________ nervous legs ______ creeping/crawling sensation of legs_________

twitching________ none_________

How often does this occur?

________times/week

How long does the sensation last?

______minutes (duration)

Does anything relieve the sensation (e.g. getting out of bed, medication, massage, etc?)

Yes______ No_____

At what age did you first experience this?

_______years of age

20. Has anyone ever told you that arms or legs jerk or twitch while you are apparently asleep?

Yes______ No_____

If yes, how often during the night does this occur?

_______times/night

How many night per week does this occur?

_______nights/week

At what age did this first come to your attention?

_______years of age

Does seem to awaken you from sleep?

Yes______ No_____

21. Have you ever experienced doing something without being aware at the time of the action?

Yes______ No_____

22. Have you ever acted out dreams?

Yes______ No_____

How often does this occur?

_______times/week

23. Has anyone in your family been known to have any sleep problems?

Yes______ No_____

If yes, please list the type of problem (e.g. trouble going to sleep, bed wetting, etc) and the person's relationship to you.

TYPE OF PROBLEM	RELATIONSHIP	TREATED?

24. Do you know or do others tell you that you: (leave blank if not)

	TIMES PER WEEK	AGE STARTED	LAST OCCURRED	TREATMENT
Talk while apparently asleep				
Walk while apparently asleep				
Grit teeth while apparently asleep				
Wet the bed during sleep				
Wake up screaming or afraid				
Have disturbing dreams				
Have unusual movements while apparently asleep				
Awaken during the night with headaches				
(Males) Have erections while asleep				

25. 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. 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
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
As a driver in a car, while stopped in traffic	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	