Please Complete &
Bring With You

Sleep Disorders Center

St. Joseph Hospital

ST. JOSEPH HEALTH SYSTEM

# Sleep Questionnaire

Name: ________________________________ Date: ____________________

Birthdate: __________________ Age: ________ Occupation: ______________________

Sex: ____________ Height: ________ Weight: ________ Weight Last Year: __________

Referring Doctor: ____________________ Family Doctor: ______________________

Briefly, what is your sleep problem? ______________________________________

_____________________________________________________________________

What results do you expect? ______________________________________________

_____________________________________________________________________

**A. *MEDICATION SURVEY***

Please list all of your PRESCRIPTION and NON-PRESCRIPTION medications.

| MEDICATION | REASON TAKEN |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

(Continue on reverse side, if necessary)

**B. *PLEASE LIST PAST OR PRESENT MEDICAL CONDITIONS OR SURGERIES***

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***MEDICATION ALLERGIES***: ______________________________________________

_____________________________________________________________________

*NAME:* ______________________ *DATE:* ______________________

## C. *SLEEP HABITS*

1. Circle the days of the week you work:

   **NONE** Monday Tuesday Wednesday Thursday Friday Saturday Sunday

2. *ON WORKDAYS*
   a. What time do you go to bed: ______________
   b. What time do you get out of bed: ______________
3. *ON NON-WORKDAYS*
   a. What time do you go to bed: ______________
   b. What time do you get out of bed: ______________
4. How long does it take you to fall asleep? ______________
5. How many times do you awaken? ______________
   a. How long do the awakenings last? ______________
   b. List any symptoms upon awakening: ______________
6. *SLEEP TIME*
   a. How many hours do you usually sleep? ______________
   (Do not include hours spent in bed awake.)
   b. How many hours does it take to make you feel rested? ______________
   c. How often do you take daytime naps? ______________
   d. How long are the naps? ______________
7. *SLEEP QUALITY*
   a. Are you refreshed upon awakening in the morning? **YES** **NO**
   b. How long does it take to fully awaken in the morning? ______________
8. Do you rarely fall asleep during the day, but suffer from extreme fatigue? **YES** **NO**
9. Grade your tendency of *FALLING ASLEEP* during the following situations:
   (0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

| | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| a. Sitting and reading | | | | |
| b. Watching TV | | | | |
| c. Sitting inactive in a public place (e.g. theater or meeting) | | | | |
| d. Lying down to rest in the afternoon | | | | |
| e. Sitting and talking to someone | | | | |
| f. In a car, while stopped for a few minutes | | | | |
| g. Sitting quietly after a lunch without alcohol | | | | |
| h. As a passenger in a car without a break | | | | |

*NAME:* ______________________ *DATE:* ______________________

**D.** ***SLEEP AND BREATHING***

1. Do you snore? (***If no skip to the next section.***) **YES** **NO**
2. Is your snoring broken by hesitations, gasps and snorts? **YES** **NO**
3. Are the hesitations long enough to frighten your sleep partner? **YES** **NO**
4. Has your snoring driven your bed partner from the bedroom **YES** **NO**
5. Do you awaken with a dry mouth? **YES** **NO**
6. Do you commonly have headaches upon awakening? **YES** **NO**

**E.** ***INSOMNIA***

1. Do you have trouble falling or staying asleep? (***If no skip to the next section***) **YES** **NO**
2. Do you worry about being able to fall asleep on time? **YES** **NO**
3. Do you feel sleepy prior to bedtime? **YES** **NO**
4. Does your mind race with thoughts when lying awake? **YES** **NO**
5. Do daytime worries keep you awake at night? **YES** **NO**
6. Does pain disturb your sleep? **YES** **NO**
7. Does heat, cold, hunger or thirst disturb your sleep? **YES** **NO**
8. Is your insomnia the primary reason your life is in disarray? **YES** **NO**
9. Do you rely on a sleeping medication? **YES** **NO**
10. Do you watch TV, read, or work in bed. **YES** **NO**
11. Do you frequently travel across several time zones **YES** **NO**

**F.** ***SLEEP DISTURBANCES***

1. Do unpleasant leg sensations at bedtime make you move your legs? **YES** **NO**
2. Do you kick or jerk your legs and/or arms during sleep? **YES** **NO**
3. Do you have sweats or awaken from sleep feeling flushed? **YES** **NO**
4. Do you awaken with a bitter or acid taste? **YES** **NO**
5. Do you frequently have nightmares or vivid dreams? **YES** **NO**
6. Do you grind your teeth or have bitten your cheek during sleep? **YES** **NO**
7. Have you ever ***walked*** or ***talked*** in your sleep? **YES** **NO**
8. Have you ever been unable to move for a few moments after awakening? **YES** **NO**
9. Have you ever seen or felt things from your dreams ***after*** awakening. **YES** **NO**
10. Have you ever had muscle weakness during laughter or anger? **YES** **NO**
11. Have you ever had unusual movements or behaviors during sleep. **YES** **NO**
    Describe: ______________________

**G.** ***PERSONAL HABITS***

1. Do you use tobacco ***now*** or in the ***past***? **YES** **NO**
   a. ***If yes***, how much, how long, & when stopped? ______________________
   b. ***If yes***, how close to bedtime is your last use? ______________________
2. Do you drink alcohol? **YES** **NO**
   a. ***If yes***, how much? ______________________
   b. ***If yes***, how close to bedtime is your last use? ______________________
3. Do you consume caffeinated beverages? **YES** **NO**
   a. ***If yes***, how much? ______________________

b. *If yes*, how close to bedtime is your last use? ______________

**H.** ***FAMILY HISTORY*** (Include age at passing and medical conditions)

| | Died | Age | Medical Conditions |
|---|---|---|---|
| Father: | ( ) | ______ | ______________________ |
| Mother: | ( ) | ______ | ______________________ |
| Bro/Sis: | ( ) | ______ | ______________________ |
| Bro/Sis: | ( ) | ______ | ______________________ |
| Bro/Sis: | ( ) | ______ | ______________________ |
| Bro/Sis: | ( ) | ______ | ______________________ |

(continue below if necessary)

1. List relatives with sleep problems, who snore, or who have depression/anxiety?

______________________ ______________________

______________________ ______________________

**I.** ***PERSONAL HISTORY*** (Check any and all that apply)

| | | | |
|---|---|---|---|
| ☐ skipped heart beats | ☐ heart failure | ☐ heart attack | ☐ heart murmur |
| ☐ high blood pressure | ☐ thyroid problems | ☐ diabetes | ☐ stroke |
| ☐ epilepsy | ☐ headaches | ☐ emphysema | ☐ sinusitis |
| ☐ nasal congestion | ☐ deviated nasal septum | ☐ enlarged tonsils | ☐ allergies |
| ☐ asthma | ☐ depression | ☐ anxiety | ☐ Bipolar disorder |

**J.** ***BED PARTNER QUESTIONNAIRE*** (What does your bed partner see you do during sleep?)

| | | |
|---|---|---|
| ☐ Light snoring | ☐ Sleep walking | ☐ Leg or body twitching |
| ☐ Heavy snoring | ☐ Sleep talking | ☐ Leg jerking |
| ☐ Pauses in breathing | ☐ Bed-wetting | ☐ Daytime sleepiness |
| ☐ Snorting | ☐ Head rocking/banging | ☐ Daytime confusion |
| ☐ Teeth grinding | ☐ A shaking fit | ☐ Depression/anxiety |

1. Have your bed partner provide additional details of the above observations.

______________________________________________

______________________________________________

**K.** ***ADDITIONAL INFORMATION***

______________________________________________

______________________________________________