SSM Center for Sleep Disorders

DEPAUL HEALTH CENTER

SLEEP DISORDERS QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: ____________________ Name: ____

Last First Middle

Age: ______________________ Date Of Birth: ______________________

Height: ______________________ Weight: ______________________

1. Please describe your sleep concerns in the space below including when it started.

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____

2. How often does this problem occur? ☐Almost every night ☐For periods of a least 1 week ☐Irregularly ☐Other ____________________

3. How long has this problem bothered you? ☐Longer than 2 years ☐1-2 years ☐Several months ☐Within the last 3 month's ☐Within the last month

4. On the scale below, please estimate the severity of your problem(s):
   ☐Mild ☐Moderate ☐Severe
   ☐Extremely Severe ☐Totally incapacitating

5. How strongly do you want help with your problems? ☐Very Much ☐Much ☐Moderately ☐Could do without

6. How do you describe your sleep problem? Check all that apply:
   ☐Difficulty in falling asleep ☐Wake up during the night ☐Wake up early in the morning
   ☐Excessive daytime sleepiness ☐Difficulty in awakening

7. Have you ever been diagnosed with a sleep condition in the past or undergone sleep testing? ☐Yes ☐No
   Please Explain:

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8. **Please rate how often you:**

	Never	Rarely	Occasionally	Frequently	Always
Awaken from sleep, short of breath………………………………..	☐	☐	☐	☐	☐
Awaken at night with heartburn or belching………………………	☐	☐	☐	☐	☐
Snore………………………………………………………………...	☐	☐	☐	☐	☐
Snore loudly enough that others complain…………………………	☐	☐	☐	☐	☐
Suddenly wake up gasping for breath during the night……………..	☐	☐	☐	☐	☐
Have breathing problems during the night (observed by self or others)…………………………………………………………………	☐	☐	☐	☐	☐
Notice your heart pounding or beating irregularly during the night..	☐	☐	☐	☐	☐
Fall asleep during the day ………………………………………..	☐	☐	☐	☐	☐
Fall asleep involuntarily……………………………………………	☐	☐	☐	☐	☐
Fall asleep while driving……………………………………………	☐	☐	☐	☐	☐
Have trouble at school or work because of sleepiness……………..	☐	☐	☐	☐	☐
Fall asleep during physical effort…………………………………..	☐	☐	☐	☐	☐
Fall asleep while laughing or crying………………………………..	☐	☐	☐	☐	☐
Experience loss of muscle tone when extremely emotional……….	☐	☐	☐	☐	☐
Feel unable to move (paralyzed) when waking or falling asleep…...	☐	☐	☐	☐	☐
Experience vivid dreamlike scenes upon awakening or falling asleep………………………………………………………………..	☐	☐	☐	☐	☐
Have nightmares……………………………………………………	☐	☐	☐	☐	☐
Have thoughts racing through your mind…………………………..	☐	☐	☐	☐	☐
Feel sad or depressed………………………………………………..	☐	☐	☐	☐	☐
Have anxiety (worried about things)………………………………..	☐	☐	☐	☐	☐
Notice parts of your body jerk………………………………………	☐	☐	☐	☐	☐
Kick during the night………………………………………………..	☐	☐	☐	☐	☐
Experience crawling and achy feelings in your legs………………..	☐	☐	☐	☐	☐
Experience any type of leg pain during the night…………………...	☐	☐	☐	☐	☐
Grind teeth during sleep……………………………………………	☐	☐	☐	☐	☐
Are bothered by pain during the day………………………………..	☐	☐	☐	☐	☐
Are awakened by pain during the night……………………………	☐	☐	☐	☐	☐
Talk in your sleep…………………..………………………………	☐	☐	☐	☐	☐
Walk in your sleep……………….………………………………...	☐	☐	☐	☐	☐
Physically act out your dreams with punching/kicking…………...	☐	☐	☐	☐	☐

9. **Check all that apply to you**:

☐Headaches	☐Home conditions bad	☐Inferiority feelings	☐Palpitations	☐Alcoholism
☐Insomnia	☐Abuse drugs or alcohol	☐Can't make decisions	☐Concentration difficulties	☐Unable to have a good time
☐Feel tense	☐Feel panicky	☐Financial Problems	☐Depressed	☐Don't like weekends and vacations
☐Unable to relax	☐Memory problems	☐Worthless	☐"Life is empty"	

10. How many hours of sleep do you get a night? ______________________________
11. What time do you go to bed on WEEKDAYS? ____________ WEEKENDS? ________
12. How long does it take for you to fall asleep? ______________________________
13. How many times do you typically wake up at night? __________________________
14. If you do wake up, on average, how long do you stay awake? ____________________
15. What do you usually do when you awaken during the night? ____________________
16. What time do you usually awaken in the morning on WEEKDAYS? ________ WEEKENDS? ________
17. On average, how long do you stay in bed after waking up in the morning? ____________
18. **Do you usually? (check all that apply to you)**

☐Sleep with someone else in your bed

☐Sleep with someone else in your room

☐Provide assistance to someone during the night (child, invalid, bed partner, animal)

19. Are your sleep habits on the weekends different from your rest on the week? ☐No ☐Yes (please explain)

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20. With whom are you now living (wife, husband, children, parents, etc)

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21. Do you work split shifts or rotating (variable) shifts? ☐YES ☐NO
22. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐YES ☐NO
23. Do you usually do physical exercise before bedtime? ☐YES ☐NO
24. Do you read before falling asleep? ☐YES ☐NO
25. Do you watch TV in bed before falling asleep? ☐YES ☐NO
26. Do you take naps during the afternoon or evening? ☐YES ☐NO
27. Do you feel refreshed after a short (10-15 minute) nap? ☐YES ☐NO

28. Please list current medications and medical conditions:

Medication	Amount	How Often	Medical Condition

29. List your consumption of the following per day:

Coffee ________ Alcohol ________ Tea ____________ Cola ________ Chocolate ________
Nicotine ________ Over the counter drugs ______________ Other drugs ________________

30. **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 estimate how they would have affected you. Use the following scale to choose the most appropriate number from each situation:

Situation	Chance of Dozing			
	Never	Slight	Moderate	High
Sitting and Reading…………………………………………………………...	☐	☐	☐	☐
Watching TV……………………………………………………………….	☐	☐	☐	☐
Sitting, inactive in a public place (theater,meeting)……………………………..	☐	☐	☐	☐
Passenger in a car for an hour without a break…………………………………..	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstance permit………………...	☐	☐	☐	☐
Sitting and talking to someone…………………………………………………..	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol…………………………………….	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic……………………………...	☐	☐	☐	☐

31. What is your personal interpretation as to why you have your particular sleep/awake problem?

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