**Sleep Disorders Questionnaire**

1. Who encouraged you to get a sleep disorders evaluation? (e.g. spouse/friend/doctor (please list name)/ hospital experience/your own concerns)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What do you hope to achieve from this consultation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What time do you usually go to bed?

 Weekdays/work or school days \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Weekends/days off \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you do any of the following in bed before turning out the lights?

 Watch TV listen to music read work computer

 Other bedtime habits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What do you do for the hour before you get into bed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. How long does it usually take to fall asleep (or give a range)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you use or have you tried any prescription or over-the-counter sleeping pills?

 Current: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What time do you get up for work or school (if applicable)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What time do you get up on weekends or non-work days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Do you use an alarm clock or clock radio to help you wake up on time? Yes No

11. How often do you wake up at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Why do you wake up at night? bathroom snoring trouble breathing anxiety

 choking feeling acid reflux or heart burn leg discomfort jumpy legs

 palpitations pain other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. If you wake at night, is it difficult to get back to sleep? Yes (explain) No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. How much total sleep do you think you get most nights? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. I wake up: How many days per week? (0-7)

 Full of energy and wide awake \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Somewhat rested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Still tired or sleepy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (lines add up to 7)

16.What position(s) do you sleep in?

 Back left side right side stomach chair hospital bed

17. Do you take naps during the day?

 Never 1-2 times a weekly 3-4 times weekly 5-6 times weekly Everyday

 How long do you nap? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you wake up from your naps refreshed? Yes No Somewhat

18. Do you snore loud enough to wake yourself or disturb others?

 Never Rarely Occasionally Frequently

19. Has anyone told you that you hold your breath or stop breathing while you sleep? Yes No

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Do you wake up with a choking feeling at night? Never Rarely Occasionally Frequently

21. Do you wake up with heartburn or acid reflux? Never Rarely Occasionally Frequently

22. Do you wake up in the morning with a headache?

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

23. Do you get up to urinate at night? Yes No How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Do you tend to sweat heavily at night? Never Rarely Often

25. Are you a restless sleeper? Yes No

 (e.g change positions a lot, toss and turn, wake up with bed sheets and blankets out of place)?

26. Do you frequently wake up with a dry mouth? Yes No

27. Do you grind your teeth or clench at night? Grind Clench Neither

28. Do you experience muscle cramps in your legs at night?

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

29. Have you been told or noticed that your arms or legs jump or twitch frequently when you sleep?

 Never Rarely Occasionally Frequently

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

30. When you try to relax in the evening or at bedtime, do you ever have unpleasant, restless feelings in your legs or arms (other than muscle cramps) that can be relieved by movement?

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

Describe the feeling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old were you when the unpleasant restless leg/arm feelings started? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. Do you sleepwalk now or have you in the past five years? Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Provide details if yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. Have you ever had a seizure (convulsion, epilepsy) while sleeping? Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

33. Do you fall asleep unintentionally during the day? (e.g. work, meeting, school, reading, TV)

 Never Rarely Occasionally Frequently

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

34. Do you frequently get sleepy or drowsy while driving? Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

35. Do you have difficulty with: short term memory focus/concentration

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

36. Do you worry or have anxiety about your sleep? Never Infrequently Frequently

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

37. How often do you dream? Never Occasionally Frequently

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

38. Have you ever woken up feeling like you were acting out a dream? Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

39. Have you ever woken up feeling like your muscles were paralyzed and you couldn’t move?

 Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

40. Have you ever felt like you:

 Started to dream before falling asleep Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Were still dreaming after you woke up Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

41. Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following situations:

 When you laugh Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 When you are angry Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 When hearing or telling a joke Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

42. Have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during any of the following situations:

 When tense or under stress Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 During or after exercise Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Other Yes No

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday

 (If Yes, please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

43. How likely are you to doze or fall asleep in the situations described below, 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 2 = Moderate chance of dozing

1 = Slight chance of dozing 3 = High chance of dozing

Situation Chance of dozing (circle a #)

Sitting and reading 0 1 2 3

Watching TV 0 1 2 3

Sitting, inactive in a public place (e.g. a theater or meeting) 0 1 2 3

As a passenger in a car for an hour without a break 0 1 2 3

Lying down to rest in the afternoon when circumstances permit 0 1 2 3

Sitting and talking to someone 0 1 2 3

Sitting quietly after a lunch without alcohol 0 1 2 3

In a car, while stopped for a few minutes in traffic 0 1 2 3