

## **SLEEP QUESTIONNAIRE**

Date:	Name:		
Describe briefly	why you are being seen at Scottsdale Insomnia and Slee	ep Medicine:	
Hawa way ayan b		Na	
nave you ever t	peen evaluated for a sleep problem? Yes	No	
If <u>yes</u> , please de	escribe:		
How long have	you had your sleep problem?		
<u>Falling aslee</u>	<u>p:</u>		
How great a pro	oblem do you have falling asleep (0-5)? (0 = no problen	n)	
What time do yo	ou usually get into bed on weekdays?	weekends?	
How long after (	getting into bed do you decide to go to sleep?		
How long does i	t take you to fall asleep?		
How many hour	s of actual <u>sleep</u> do you get on an average night?		
Do you worry or	ruminate as you try to sleep? yes no		
If <u>yes,</u> please de	escribe:		
While falling as	sleep do you ever:		
	nove (paralyzed)	yes	no
•	ess legs (or irresistable urge to move legs)	yes	no
•	I dream-like scenes although you know you are awake kind of pain or discomfort	yes yes	no no
	scribe:		

### Staying asleep:

#### Is your sleep disturbed by:

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Sweating Asthma	yes	no no	Snoring If yes: Is it loud?	yes	no no
Headache	yes yes	no	Are you disruptive to others?	yes yes	no
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Talking in your sleep	yes	no	Heartburn/Reflux	yes	no
Falling out of bed	yes	no	Grinding your teeth	yes	no
Frequent Nightmares	yes	no	Nasal congestion	yes	no
Thrashing movements	yes	no	Difficulty breathing	yes	no
Frequent Muscle cramps	yes	no	Holding your breath	yes	no
Leg twitching/restless legs	yes	no	Gasping for breath	yes	no
9	,		a aspenia con a com	,	
Sleep walking	yes	no	Chronic nocturnal cough	yes	no
Falling out of bed	yes	no	Heart pounding in your chest	yes	no
Bed wetting	yes	no	Need to urinate	times	
Have you ever injured or	almost iniu	rad valuraalf d		\/OS	no
· · · · · · · · · · · · · · · · · · ·	-	•	or your bedpartner while asleep?	yes	no
	: inclaent(	5)			
If yes, please describe the					
<u>ir yes</u> , piease describe me					
Night Awakenings:					
Night Awakenings:			.10		
Night Awakenings:  How many times do you d		-	ntś		
Night Awakenings:  How many times do you of How long does each awayen	ıkening usı	ually last?			
Night Awakenings:  How many times do you d	ıkening usı	ually last?			
Night Awakenings:  How many times do you of How long does each away What is the total time that	kening usi you are c	ually last? wake during			
Night Awakenings:  How many times do you of How long does each away what is the total time that Why do you awaken during the second sec	kening using you are congiting the nigh	ually last? wake during nt?	the night?		
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# **Morning:**

What time do you awaken in the morning on:	weekdays?	weekends?
Do you have difficulty awakening in the morning?	yes	no
Have you ever been unable to move when you awake	en? yes	no
Do you cough up sputum upon awakening?	yes	no
Do you wake up with a morning headache?	yes	no
Do you awaken from sleep screaming, violent or confu <u>If yes</u> , what exactly do you experience?	yes yes	no no

#### **Daytime:**

Do you have a problem with daytime sleepiness? No matter how much you sleep do you still feel tired? Have you ever fallen asleep while driving a motor vehicle?	yes yes yes	no no no		
If yes, describe any accidents that have resulted:				
Do you ever have the sensation of weak knees when you laugh?	yes	no		
Have you ever fallen limp to the ground when excited without losing consciousness or fainting?	yes	no		
If sleepy how likely are you to doze off or fall asleep in the following situations?				

it sleepy, now likely are you to doze off or fall asleep in the following situations?

**0**=never, **1**= slight, **2**= moderate, **3**=high (circle one response)

Sitting & reading Watching TV Sitting in a public place

As a passenger in a car for an hour Lying down to rest in the afternoon Sitting & talking to someone

Sitting quietly after a lunch without alcohol In a car, stopped for a few minutes in traffic

Total	Score:	
10101	30010.	

Napping: (actually falling asleep for five minutes or more)

Do you nap on weekdays? On weekends?	yes yes	no no		
How many days per week?				
How many naps/day?		Average length	of nap	
What time(s) do you nap?				
Do you feel refreshed after a nap?	yes	moderately	not at all	

<u>Daytime Habits</u> :					
How many <b>cups/day</b> do you drink:c			caffeinated coffee/tea caffeinated soft drinks		
How much beer, wine o	r liquor do y	ou drink <b>p</b>	er week?		
Do you regularly drink a alcoholic beverage with			Ş	yes	no
Do you smoke?	yes	no	If yes, how many packs <b>per</b>	day?	
Do you smoke prior to b	edtime or w	hen awak	kening during the night?	yes	no
Do you exercise?	yes	no	<u>If yes</u> , hours/week		
What exercise?					
<u>Previous Treatment</u>	for Sleep	<u>Probler</u>	<u>ns:</u>		
Have you ever been to	reated for:				
Insomnia?  If yes, please list any me	yes dications ar	no nd/or trea	tments:		
Sleep Apnea ?	yes	no			
If yes, with what treatme	ent:				
CPAP Dental Appliance Surgery	yes yes yes	no no no	pressure setting: specify type:		
Other Sleep Disorder?	VOS	no			
If yes, please check any	yes that apply:	no			
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Restless Legs Syndrome			Periodic Limb Movement Disorder		
Narcolepsy			Parasomnia (sleepwalk	ing/sleep terroi	rs)
Other					

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