LABEL

SLEEP QUESTIONNAIRE
Center for Sleep Disorders
St. Agnes Hospital, Fond du Lac, WI

SLC-0010 (11/15/13) ORDER FROM PRINTING

• General Information

Name: _____ Date:_____

Gender: ❑ Male ❑ Female Age:_____ DOB: _____

Home phone#: _____ Alternative phone #: _____

Work phone#: _____ May we call you at work? ❑ Yes ❑ No

Current Occupation/Company: _____

Height: _____ feet _____ inches Current Weight: _____ Lbs. Neck circumference:_____

Referring physician:_____Family physician: _____

What is your primary problem with sleep?_____

How long have you had this sleep problem? _____ months _____ years

List other problems with your sleep (indicate duration in months/years):

a) _____

b) _____

c) _____

Have you had a sleeping problem diagnosed in the past? ❑ Yes ❑ No

If yes, what was the problem and what treatment(s) was/were recommended? _____

_____

Did the treatment(s) help? _____

Where was the diagnosis made? _____

• Sleep Schedule and Sleep Hygiene

What time do you usually go to bed on weekdays?..... ___:___ A.M. P.M.

What time do you usually get up on weekdays?..... ___:___ A.M. P.M.

What time do you usually go to bed on weekends? ..... ___:___ A.M. P.M.

What time do you usually get up on weekends? ..... ___:___ A.M. P.M.

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How many hours do you usually sleep on weekdays that you work? _____

How many hours do you usually sleep on weekends that you don't work? _____

Are you usually refreshed by a nights sleep? ..... ❑ Yes ❑ No

Do you keep a fairly regular sleep/wake schedule? ..... ❑ Yes ❑ No

Do you nap during the day? ..... ❑ Yes ❑ No

If yes, how many naps per day? _____

How long do they average? _____

Are you refreshed by your naps? ..... ❑ Yes ❑ No

Do you read in bed? ..... ❑ Yes ❑ No

Do you watch TV in bed? ..... ❑ Yes ❑ No

Do you write in bed? ..... ❑ Yes ❑ No

Do you eat in bed? ..... ❑ Yes ❑ No

Do you eat prior to bedtime? ..... ❑ Yes ❑ No

Do you currently do shift work? ..... ❑ Yes ❑ No

Have you done shift work in the past? ..... ❑ Yes ❑ No

If yes to either of the last two questions, do you have trouble sleeping when you are doing shift work? ..... ❑ Yes ❑ No

If you could set your own schedule:

What time would you go to bed? _____:_____ A.M. P.M.

What time would you get up? _____:_____ A.M. P.M.

• Insomnia

Answer the following questions based on your experience in the last six months, with "night" meaning your major sleeping time.

Do you often have trouble getting to sleep at night? ..... ❑ Yes ❑ No

What is the average number of minutes it takes you to fall asleep at night? _____ minutes

Do you often have awakenings during the night? ..... ❑ Yes ❑ No

If yes, average number of times per night?_____

If yes, why do you awaken? _____

Do you awaken and have trouble falling back to sleep? ..... ❑ Yes ❑ No

If yes, how long are these periods of wakefulness when added together? _____ minutes per night?

Have you ever been told you make unusual movements such as talking, swinging arms about, acting out dreams, etc. during sleep? ..... ❑ Yes ❑ No

If yes, how frequently? _____ per week / month / year (circle one)

What age did they begin? _____ years

Please describe _____

Have you ever caused injury to yourself or others when you were asleep? ..... ❑ Yes ❑ No

If yes, how frequently? _____per week / month / year (circle one)

Please describe: _____

• Movement

Answer the following questions based on the most recent six months.

Are your bed covers extremely messy in the morning when you wake up? ..... ❑ Yes ❑ No

Do you awaken yourself by kicking your legs during the night? ..... ❑ Yes ❑ No

Has your bed partner ever complained of your legs kicking during the night? ..... ❑ Yes ❑ No

Do you have restless sense of discomfort (crawling movement) in your legs during the waking hours? ..... ❑ Yes ❑ No

Do you exercise regularly? ..... ❑ Yes ❑ No

• Excessive Sleepiness

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**
NA = not applicable

Situation	**Chance of dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	TOTAL_____

Are you bothered by waking up too early and not being able to get back to sleep? ❑ Yes ❑ No

If yes, what is the average number of nights per week?_____ night(s) per week

How many nights a week do you feel you have a sleep problem? _____ night(s) per week

Is your sleep disrupted by your bed partner? ❑ Yes ❑ No

If yes, what disturbs you? ❑ Snoring ❑ Movement ❑ Other:_____

_____

• Parasomnias

Did you have a sleep problem as a child? ❑ Yes ❑ No

If yes, describe: _____

_____

Do you currently have nightmares or night terrors? ❑ Yes ❑ No

If yes, how frequently? _____ per week /month / year (circle one)

What age did they begin? _____ years

Do you grind or clench your teeth at night? ❑ Yes ❑ No

Did you frequently wet the bed as a child? ❑ Yes ❑ No

Have you ever been told that you walk in your sleep? ❑ Yes ❑ No

Have you recently walked in your sleep? ❑ Yes ❑ No

Have you ever felt sudden muscle weakness when you laughed, got angry or were surprised? ❑ Yes ❑ No

If yes, describe: _____

Have you ever been unable to move your body just as you were falling asleep or waking up? ❑ Yes ❑ No

If yes, describe: _____

Do you have difficulty distinguishing your dreams from reality? ❑ Yes ❑ No

If yes, describe: _____

• General

How often do you wake with morning headaches? ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

Have you ever been told that you stop breathing during your sleep? ❑ Yes ❑ No

If yes, how often do you stop breathing during sleep? ❑ Some nights ❑ Every night

Have you ever awoken with a snort, choking sensation, or short of breath? ❑ Yes ❑ No

If yes, how often does this occur? ❑ Some nights ❑ Every night

How often do you snore? ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

How loud is your snoring? ❑ Not very ❑ Somewhat ❑ Very

In which position(s) do you prefer to sleep? _____

Do you feel excessively sleepy in the daytime? ❑ Yes ❑ No

If yes, how long: _____ months / years (circle one)

Do you feel that your sleepiness is a result of poor quality of nighttime sleep? ❑ Yes ❑ No

Have you ever had an accident or a near-miss because of falling asleep driving? ..... ❑ Yes ❑ No

If yes, describe: _____

Does sleep position affect your snoring? ..... ❑ Yes ❑ No

Do you have difficulty breathing through your nose? ..... ❑ Yes ❑ No

Have you ever had surgery on your upper airway? ..... ❑ Yes ❑ No

If yes, describe:_____

Do you have heartburn, gastric reflux, or hiatal hernia? ..... ❑ Yes ❑ No

Do you use oxygen or any type of medical equipment when you sleep? ..... ❑ Yes ❑ No

If yes, describe:_____

Please recall your weight history – enter "NA" if not applicable.

Weight at age 20 _____ Lbs Weight at age 50 _____Lbs

Weight at age 30 _____ Lbs Weight at age 60 _____Lbs

Weight at age 40 _____ Lbs Heaviest weight _____Lbs, age ____

If you have gained weight, do you feel sleepiness is associated with weight gain? ..... ❑ Yes ❑ No

Have you attempted to diet? ..... ❑ Yes ❑ No ❑ NA

If yes, your maximum weight loss was _____Lbs

Are you successful at keeping your weight off? ..... ❑ Yes ❑ No

Please list your current medical problems, such as high blood pressure, heart disease, stroke, lung disease, etc.

a) _____

b) _____

c) _____

• Family History

Do other members of your immediate family (e.g. father, mother, siblings, children) snore? ..... ❑ Yes ❑ No

If yes, explain _____

Do other members of your immediate family have excessive daytime sleepiness? ..... ❑ Yes ❑ No

Do other members of your immediate family have any other problems with sleep? ..... ❑ Yes ❑ No

If yes, explain _____

_____

• Psychological History

Do you feel depressed? ..... ❑ Yes ❑ No

If yes, how often? _____

Do you feel depressed now? ..... ❑ Yes ❑ No

Have you had a personality change? ..... ❑ Yes ❑ No

If yes, describe _____

Have you ever seen a psychiatrist or any other type of counselor? ..... ❑ Yes ❑ No

Currently? ..... ❑ Yes ❑ No

• Social History

Have you ever smoked cigarettes? ..... ❑ Yes ❑ No

Do you currently smoke cigarettes? ..... ❑ Yes ❑ No

If yes, how many packs per day? _____

Years of smoking? _____

If you quit smoking, when did you quit? _____

Have you ever smoked cigars, a pipe or chewed tobacco? ..... ❑ Yes ❑ No

Currently? ..... ❑ Yes ❑ No

Please indicate the number of cups per day consumed of the following beverages:

Caffeinated coffee (8oz) _____

Caffeinated tea (8oz) _____

Caffeinated soft drinks (12oz) _____

Do you currently smoke marijuana or take any other mood altering illicit drugs? ..... ❑ Yes ❑ No

If yes, what and how often? _____

Did you ever drink alcohol? ..... ❑ Yes ❑ No

Do you currently drink alcohol? ..... ❑ Yes ❑ No

If yes, on the average, how many alcoholic drinks do you take on weekdays (working days)? ____ per day

On the average, how many alcoholic drinks do you take on weekends (non working days)? _____ per day

Please list medications that are taken (both prescribed and over the counter): _____

_____

_____

_____

_____

Additional comments regarding your sleep: _____

_____

_____

_____

_____

Please sign to verify all information is true: _____

Date: _____ Time: _____

Thank you for your cooperation in completing this questionnaire!

St. Agnes Hospital
Center for Sleep Disorders
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Fond du Lac, WI 54935

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LABEL

BED PARTNER QUESTIONNAIRE
Center for Sleep Disorders
St. Agnes Hospital, Fond du Lac, WI

Patient name:_____ Date: _____

TO BE COMPLETED BY BED PARTNER.

Check any of the following behaviors that you have observed the patient doing while asleep.

❑ loud snoring
❑ light snoring
❑ twitching of legs or feet during sleep
❑ pause in breathing
❑ grinding teeth
❑ sleep talking
❑ sleep walking
❑ bed wetting
❑ sitting up in bed but not awake
❑ becoming very rigid and/or shaking
❑ kicking with legs during sleep
❑ getting out of bed but not awake
❑ biting tongue

How long have you been aware of the sleep behavior(s) that you checked above? _____

_____

_____

_____

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night. _____

_____

_____

_____

_____

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud “snorts”? _____

_____

_____

_____

_____

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