



## Clinical Sleep Disorders Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_  
 Address \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_  
 Phone Number (    ) \_\_\_\_\_ SSN # \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

**Please consult your bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write in your own if one the choices does not apply.**

1. Please describe your sleep pattern as best as you can: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. What is the most you have ever weighed? \_\_\_\_\_  
 What did you weigh 5 years ago? \_\_\_\_\_  
 What did you weigh 1 year ago? \_\_\_\_\_

3. When did your sleep problem begin? (month and/or year) \_\_\_\_\_

4. Have you ever had a sleep study before? ( )Yes ( )No  
 If yes, where was the test performed? \_\_\_\_\_  
 When was the test performed? \_\_\_\_\_  
 What were the results? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Please list your current medications (use back of page if necessary):

MEDICATION		LAST TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**DOSE/FREQUENCY**

**PT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

6. My ideal amount of sleep is \_\_\_\_\_ hours per night.

During the week I usually:

During the weekend I usually:

go to bed at \_\_\_\_\_ (TIME)  
get up at \_\_\_\_\_ (TIME)  
sleep a total of \_\_\_\_\_ (HOURS)

go to bed at \_\_\_\_\_ (TIME)  
get up at \_\_\_\_\_ (TIME)  
sleep a total of \_\_\_\_\_ (HOURS)

7. My job requires shift work ( )YES ( )No If yes, my hours are \_\_\_\_\_

8. It usually takes me \_\_\_\_\_ minutes to fall asleep.

9. I usually wake up \_\_\_\_\_ times during the night. Please explain what wakes you up: \_\_\_\_\_  
\_\_\_\_\_

10. I have difficulty going back to sleep once I wake up.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

Suspected cause: \_\_\_\_\_

11. I snore:

NIGHTLY                  WEEKLY                  RARELY                  NEVER

12. My snoring started at age: \_\_\_\_\_

13. I snore in all sleeping positions. ( )YES ( )NO

14. My snoring has been described as: ( )MILD ( )MODERATE ( )LOUD

15. I have problems with my nose or nasal breathing ( )YES ( )NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

16. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:

NIGHTLY                  WEEKLY                  RARELY                  NEVER

17. I have been told that I toss and turn to an extreme amount.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

**PT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

18. Immediately after falling asleep, I dream.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

19. I have been told that I talk or scream in my sleep.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

20. I have been told that I grind my teeth while I sleep.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

21. I wake up with a sour or stomach acid taste in my mouth.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

Last meal is eaten at what time? \_\_\_\_\_ a.m. / p.m.

22. I wake up with my heart beating irregularly.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

23. I wake up at night with muscle or joint aches and pains.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

24. I have the feeling of burning or tingling in my legs or the feeling of restless legs.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

25. I feel like I cannot move after lying down, before going to sleep.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

26. I see or hear things that are not real when lying in bed, but not asleep.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

Type of sound or visualization: \_\_\_\_\_

27. After a typical night's sleep, I feel stiff or achy.

NIGHTLY                  WEEKLY                  RARELY                  NEVER

28. After a typical night's sleep, I feel:

( ) Refreshed ( ) Fairly rested ( ) Somewhat tired ( ) Very drowsy

**PT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

29. I take naps. ( )YES ( )NO If yes, how many per day? \_\_\_\_\_

If no, is there a reason why you do not take naps?

( ) NO NEED ( ) NO TIME ( ) WORK/SOCIAL DOES NOT PERMIT

30. I fight sleep uncontrollably for short periods of time while sitting.

DAILY WEEKLY RARELY NEVER

This occurs when (circle each that applies):

Watching T.V. During Meetings At the Movies Riding in a Car

Other: \_\_\_\_\_

31. If fight sleep while driving.

DAILY WEEKLY RARELY NEVER

This last occurred when?: \_\_\_\_\_

This primarily occurs (circle the one that applies): Morning Afternoon Evenings

32. I have fallen asleep while driving a car. ( )YES ( )NO

If yes, how many times? \_\_\_\_\_ Approximate date of last occurrence: \_\_\_\_\_

Please describe the circumstances: \_\_\_\_\_

\_\_\_\_\_

33. I dream during my naps.

DAILY WEEKLY RARELY NEVER

34. After my naps, I feel:

( ) REFRESHED ( ) FAIRLY RESTED ( ) SOMEWHAT TIRED ( ) VERY DROWSY

35. I feel a sudden weakness in my knees, neck, jaw, or arms when I get angry, sad, while laughing or when emotional.

DAILY WEEKLY RARELY NEVER

35. I have episodes of doing strange things without realizing it or losing a period of time.

DAILY WEEKLY RARELY NEVER

**PT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

36. Drowsiness is greatest in the ( )MORNING ( )AFTERNOON ( )EVENING

37. Within the last year, depression, anxiety, or stress has interfered with my sleep:  
( )YES ( )NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

38. Is there a history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring? \_\_\_\_\_

39. I have lost interest in sex or have trouble functioning sexually?

NIGHTLY WEEKLY RARELY NEVER

40. My spouse or bed partner has noticed that I quit breathing at night.

NIGHTLY WEEKLY RARELY NEVER

41. I have headaches in the morning.

NIGHTLY WEEKLY RARELY NEVER

42. Do you smoke or have you smoked? ( )YES ( )NO

If yes, how many years have (did) you smoked? \_\_\_\_\_

How many cigarettes (cigars) per day? \_\_\_\_\_

If you quit, how long ago? \_\_\_\_\_

43. Do you drink caffeinated beverages? ( )YES ( )NO

If yes, how many cups or cans per day? \_\_\_\_\_

My usual beverage is: ( )COFFEE ( )TEA ( )SODA

44. I consume alcohol. ( )YES ( )NO

If yes, how often? ( )DAILY ( )WEEKLY ( )MONTHLY

I usually drink in the: ( )MORNING ( )AFTERNOON ( )EVENING

My usual beverage is: \_\_\_\_\_

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PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

**PT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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  
1 = **slight** chance of dozing  
2 = **moderate** chance of dozing  
3 = **high** chance of dozing

	SITUATION	CHANCE OF DOZING
1.	Sitting and reading	_____
2.	Watching television	_____
3.	Sitting inactive in a public place, (theater, meeting, etc...)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon when circumstances permit	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly after lunch without alcohol	_____
8.	In a car, while stopped, for a few minutes in traffic	_____
	Total Score	_____

## CPAP COMPLIANCE

1. Do you use your CPAP or BiLevel therapy every night? (Y/N) \_\_\_\_\_
2. Do you use your CPAP or BiLevel therapy all night? (Y/N) \_\_\_\_\_
- If no, how many hours per night do you use your machine? \_\_\_\_\_

Thank you for your cooperation

# Bed Partner Questionnaire

Name Of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

I have observed this patient's sleep:

Never       Once or twice       Often       Every night

Check any of the following behaviors that you have observed this person doing while asleep. Circle those that you consider severe problems for this person

- |   |  |
|---|--|
| <input type="checkbox"/> Light snoring  | <input type="checkbox"/> Loud snoring                |
| <input type="checkbox"/> Occasional loud snorts                               | <input type="checkbox"/> Choking                     |
| <input type="checkbox"/> Pauses in breathing                                  | <input type="checkbox"/> Twitching or kicking legs   |
| <input type="checkbox"/> Sleep talking  | <input type="checkbox"/> Grinding teeth              |
| <input type="checkbox"/> Bed wetting  | <input type="checkbox"/> Sitting up in bed not awake |
| <input type="checkbox"/> Awakening with pain                                  | <input type="checkbox"/> Head rocking or banging     |
| <input type="checkbox"/> Getting out of bed not awake                         | <input type="checkbox"/> Biting tongue               |
| <input type="checkbox"/> Becoming very rigid and/or shaking                   | <input type="checkbox"/> Crying out                  |
| <input type="checkbox"/> Apparently sleeping even if he/she behaves otherwise |  |

If the person snores, what makes it worse?

- |   |   |
|---|---|
| <input type="checkbox"/> Sleeping on their back | <input type="checkbox"/> Sleeping on their side |
| <input type="checkbox"/> Alcohol                | <input type="checkbox"/> Fatigue                |

Describe the sleep behaviors checked in more detail. Include a description of the activity, the time of night it occurs, and the frequency this behavior happens.

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Has this person ever fallen asleep during normal daytime activities, or in dangerous situations?   
Yes       No      If yes please explain: \_\_\_\_\_

Does this person use sleeping pills?  Yes       No

If yes how many times per week?

1-3 times a week       4-7 times a week

Do you consider this usage a problem?  Yes       No

Comments: \_\_\_\_\_  
\_\_\_\_\_