(Patient Label Here)

Sleep Questionnaire (Short Version)

Please seek your bed partner's assistance in completing this questionnaire if they are available.
Complete this questionnaire prior to leaving the clinic today.

General Information

Name: ____ Date: ____________________

What is your primary problem with sleep? ____

____

How long have you had the sleep problem? _______ months _______ years

Have you had a sleep 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? □ Yes □ No

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 _____ hours

Do you often have awakenings during the night? □ Yes □ No

If "yes", why do you awaken? ____

Do you have long periods when you awaken and are not able to return to sleep? □ Yes □ No

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

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? ________ nights per week

How many nights a week do you feel you have a sleep problem? _________ nights per week

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

If yes, what disturbs you? □ Snoring □ Movement □ Other (describe)___________________________

(08/2015)

Parasomnias

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

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

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

Have you ever been told that you make unusual activities such as talking, swinging your arms, acting out dreams, etc., during your sleep? □ Yes □ No

Have you even caused injury to yourself or others when you were asleep? □ Yes □ No

Excessive Sleepiness

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 = No chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	______________
Watching TV	______________
Sitting inactive in a public place i.e. a theater or meeting	______________
As a passenger in a car for an hour without a break	______________
Lying down to rest in the afternoon when circumstances permit	______________
Sitting and talking to someone	______________
Sitting quietly after a lunch without alcohol	______________
In a car stopped for a few minutes in traffic	______________
TOTAL:	______________

Have you ever had an accident or near miss accident because of falling asleep driving? □ Yes □ No

If yes, describe: ____

Does your sleepiness interfere with your performance at work or school? □ Yes □ No

Symptoms Associated with Sleepiness

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: ____