



Wasatch Sleep Health Center

Sleep Questionnaire
(801) 281-1788

Date: ____/____/____

This is a questionnaire about your typical sleep habits over the past one month. **Please ask your bed partner to assist you with answering the following questions.**

Patient Name: _____
Last First M.I.

Age: _____ Current Occupation: _____

1. The most bothersome or distressing **symptom** that I feel is:

2. The most worrisome **concern** that I have about my sleep problem is:

3. The most important thing **I need to get** out of this clinic visit is:

4. I have snoring that bothers other people: _____ YES _____ NO

5. I only snore when I am lying flat on my back: _____ YES _____ NO

6. I have been snoring for _____ years. _____ YES _____ NO

7. I have been told that I stop breathing in my sleep: _____ YES _____ NO

8. I have awakened feeling short of breath or choking: _____ YES _____ NO

9. I have problems breathing through my nose at night: _____ YES _____ NO

10. If I wanted to and if given the chance in a quiet situation, I could fall asleep at almost
anytime of day: _____ YES _____ NO

11. I have too many thoughts when I am in bed: _____ YES _____ NO

12. At night, I am usually quite concerned about whether I will be able to fall asleep and stay asleep: ☐ YES ☐ NO
13. I have relied on sleeping pills: ☐ TRUE ☐ FALSE
14. My legs bother me at night: ☐ YES ☐ NO
15. Strange things happen to me as I am falling asleep: ☐ YES ☐ NO
16. I have a change in my muscle control if I experience a sudden, strong emotion: ☐ YES ☐ NO
17. I received bad grades in school because of sleepiness: ☐ YES ☐ NO
18. I have trouble on the job because of sleepiness: ☐ YES ☐ NO
19. I often fight sleepiness while driving: ☐ YES ☐ NO
20. I have driven my car somewhere but then, on arrival, have been unable to remember a large part of the drive: ☐ SOMETIMES ☐ NEVER
21. If I do take a daytime nap, it is refreshing: ☐ YES ☐ NO
22. If I do take a nap, I may have a dream: ☐ SOMETIMES ☐ NEVER
23. I have a shift work schedule: ☐ YES ☐ NO
24. I have a strong tendency to go to sleep late, sleep soundly and then wake up late: ☐ YES ☐ NO
25. I walk in my sleep: ☐ YES ☐ NO
26. I talk or scream in my sleep: ☐ YES ☐ NO
27. I do violent things in my sleep: ☐ YES ☐ NO
28. I have unwanted behaviors in my sleep: ☐ YES ☐ NO

TYPICAL WEEKDAY SLEEP SCHEDULE

29. I get into bed at about: _____ to _____ p.m / a.m.
30. I turn out the lights at about: _____ to _____ p.m. / a.m.
31. It takes between: _____ and _____ minutes to fall asleep.
32. I wake up between _____ and _____ times per night.
33. I have difficulty getting back to sleep: ☐ USUALLY ☐ RARELY
34. My final awakening is at about: _____ To _____ p.m./ a.m.

35. After my final awakening, I usually get out of bed: ____ IMMEDIATELY ____ AFTER MORE THAN 30 MIN.

TYPICAL WEEKEND SLEEP SCHEDULE

36. I get into the bed at about: _____ to _____ p.m./ a.m.
37. I turn out the lights at about: _____ to _____ p.m./ a.m.
38. It takes between: _____ and _____ minutes to fall asleep.
39. I wake up between: _____ and _____ times per night.
40. I have difficulty getting back to sleep: ____ USUALLY ____ RARELY
41. My final awakening is at about: _____ to _____ p.m./ a.m.
42. After my final awakening, I usually get out of bed: ____ IMMEDIATELY ____ AFTER MORE THAN 30 MIN.
43. I smoked cigarettes for _____ years.
44. My caffeine consumption is about _____ per day.
45. My weekday alcohol consumption is about _____ per day.
46. My weekend alcohol consumption is about _____ per day.

MEDICATIONS I AM CURRENTLY TAKING

<u>NAME</u>	<u>DOSAGE</u>
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

OTHER COMMENTS: _____

EPWORTH SLEEPINESS SCALE (ESS)

Instructions:

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

1 = slight chance of dozing off

2 = moderate chance of dozing off

3 = high chance of dozing off

SITUATION:

CHANCE OF DOZING:

- | | |
|--|-------|
| 1. Sitting and reading | _____ |
| 2. Watching T.V. | _____ |
| 3. Sitting inactive in a public place (e.g. in a theater or meeting) | _____ |
| 4. As a passenger in a car for an hour without a break | _____ |
| 5. Lying down to rest in the afternoon when the 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*

Wasatch Sleep Health Center
1151 East 3900 South, Suite B240 • Salt Lake City • Utah • 84124
Phone: (801) 281-1788 • Fax (801) 281-2788