SUNY Upstate Medical University
UniversityHospital

National Sleep Technologies Sleep Questionnaire

Welcome to our sleep clinic! The following questions will help us understand more about you. These questions will also help the physician when he looks at your sleep study. Please ask your bed partner to help you answer these questions. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Do not leave any questions unanswered. You may add comments to any of your answers in the margin beside the question. PLEASE PRINT.

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Last name	First name	Middle name

Address: Street

City	State	Zip

Home Phone Number:	Work Phone Number:

Date of Birth:	Age:	Sex:	Race: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other:	Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated

Occupation

Height:	Weight	Neck Circumference in Inches:	Has there been any recent weight gain or loss? ☐ Yes If yes, A gain of: _____ or a loss of: _____ lbs. ☐ No	Over how many months has this weight gain or loss occurred?

Health care Professional who referred you to us for your sleep testing. (Doctor, Physician's Assistant or Nurse Practitioner)

Here's how to answer the questions using our number scale:
1 = Rarely or never; **2** = Sometimes **3** = Often; **4** = Frequently; **5** = Always
If your answer to any question is "**no**" please check "**no**"

1. Your main complaint (s) is: ☐ Snoring ☐ My breathing stops ☐ I am sleepy ☐ I talk or walk in my sleep ☐ I can't fall asleep ☐ Other (please comment):

_____

2. How long have you had this problem? About _____ months; About _____ years
3. How has this problem affected your life? _____

_____

4. I feel that I get enough sleep at night. . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
5. I feel that I get too much sleep at night. . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
6. On average how many hours do you sleep during a 24 hour period? _____ hours
7. What time do you go to bed at night? _____ : _____
8. What time do you wake in the morning? _____ : _____
9. Do you vary this pattern on weekends? . . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   If you do, please specify the pattern: _____
10. No matter how much sleep I get I wake up feeling tired. . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
11. Do you have a problem with your performance at work because you are tired? . . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
12. Have you fallen asleep at work? . . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
13. Have you fallen asleep while driving? . . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
14. Do you sleep with a bed partner? . . . . . ☐ Yes ☐ No
15. I tend to fall sleep during sex. . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
16. Do you have a problem with sexual function? . . . . . ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

17. Do you snore? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
18. Does your snoring disturb others? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
19. Do you hold your breath or gasp for air in your sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
20. I have trouble breathing at night. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
21. My sleep is disturbed by my tossing and turning at night. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
22. I sweat excessively during the night. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
23. I wake up in the morning with a headache. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
24. I have asthma attaches during sleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
25. My legs seem to kick constantly during sleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
26. There are times when I must fall asleep and can not. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
27. I have felt muscle weakness when I have strong emotional feelings. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
28. I have vivid dreams right after I fall asleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
29. I am unable to move when I wake up. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
30. A nap does not make me feel refreshed. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
31. Do you purposely nap on weekdays? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
32. How often do you nap and how long do you nap for?

_____

33. What time do you nap? _____ ☐ AM _____ ☐ PM
34. I have a problem falling asleep at night. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
35. How long does it usually take you to fall asleep? _____ minutes
36. I require special conditions to fall asleep at night. (i.e. music, television) . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
37. As I try to fall asleep I have anxious thoughts race through my head. . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
38. I awaken with anxiousness, dread or worry. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
39. On average, how many times do you wake up during the night? _____
40. About how long do you spend awake during the night? _____
41. Is your sleep disturbed by a medical problem? . . . . . ☐ Yes ☐ No
    If yes, please list problem: _____
42. I awaken because of aches, pains, and headaches. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
43. As a child, did you have a problem falling asleep or awaking in the morning? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
44. Do you have trouble going back to sleep if you wake up during the night? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
45. I am bothered by outside noises during the night, such as planes, trains, or barking dogs. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
46. I tend to fall asleep when not trying to, or in a place other than my bedroom . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
47. As bedtime approaches I become more anxious. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
48. When I am awake at night I will lie there until I fall back to sleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
49. Because of my poor sleep at night I feel fatigued or "'washed out" during the day. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
50. I have a crawling, creeping feeling in the back of my legs which keeps me from failing asleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
51. Do you now, or did as a child do some sort of body rocking or head movements during sleep? . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
52. Do you now, or as a child, awaken in a room other that the one you went to sleep in? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
53. Are you now, or have you ever been a sleepwalker? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
54. According to your bed partner have you ever seemed to be acting out a dream while asleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5

55. Do you now, or did you as a child, wet the bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
56. Do you now, or have you ever suffered from nightmares? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
57. According to your bed partner, have you ever woke up screaming in fear or woke up agitated? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
58. Do you now, or have you ever had seizures in your sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
59. I awaken In a state of panic or distress. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
60. I talk during my sleep. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
61. I grind my teeth when I am steeping. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
62. I feel "groggy" or "sleep drunk" when I wake up in the morning. . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
63. Do you work a swing shift? . . . . . ☐ Yes ☐ No
    What hours do you work? _____
    If you do, does your shift rotate in a clockwise direction? . . . . . ☐ Yes ☐ No
64. Do you go to bed at the same time every night? . . . . . ☐ Yes ☐ No
65. Do you fall asleep earlier than you want to, sleep normally, then awake in the early morning hours? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
66. Do you feel sleepy late night, then receive less sleep due to a necessary wake up time? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
67. If you were able to sleep longer, would you feel rested? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
68. Do you sleep in several periods of small time during a 24 hour period? . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
69. Do you have significant stress, in your life at the present time? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
70. Do you presently feel sad or depressed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
71. Have you ever been seen by a psychologist or psychiatrist? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
72. Do you take medications to stay awake or to fall asleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
73. Do you sleep in a waterbed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
74. Do you eat 1-2 hours before sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
75. Do you smoke before sleep? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
76. Do you exercise before bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
77. Do you sleep alone? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
78. Do you watch TV nightly in bed? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
79. Have you ever had a sleep study before? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
80. Do you have any relatives with sleep disorders? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5
81. Do you use recreational drugs? . . . . . ☐No ☐1 ☐2 ☐3 ☐4 ☐5

PLEASE LIST YOUR INTAKE OF THE FOLLOWING

Coffee		Per		Liquor	Per		Tea	Per	
Beer		Per		Soda	Per		Cigarettes	Per	
Cigars		Per		Pipes	Per		Snuff	Per	

What time was your last intake of any of the above? _____
Which was It? _____
Are you allergic to any medications that you are aware of? . . . . . ☐ Yes ☐ No
If yes, please write the medications on the line below:

_____

_____

Do you have any other past or present medical or psychiatric problems or have you had any recent surgeries? Please write them below: _____

_____

_____

_____

Have any of your family members had or currently have a sleep disorder? Please note below:

_____

_____

PLEASE LIST YOUR MEDICATIONS, BOTH PRISCRIPTION AND OVER THE COUNTER

Medication	How much?	How often?

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall sleep 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 sleep 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

Situation	**Chance of Dozing**
Sitting and reading:	
Watching Television:	
Sitting, Inactive in a public place: (i.e. 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 quietly to someone:	
Sitting quietly after lunch without alcohol:	
In a car, while stopped for a few minutes in traffic:	
Total:	

THANK YOU FOR YOUR COOPERATION.