



# SLEEP DISORDERS CENTER

The Bellevue Hospital

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## SLEEP QUESTIONNAIRE

Please answer these questions regarding your sleep habits as completely as possible. You may receive help from your spouse, bed-partner, or roommate if necessary.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Evaluation \_\_\_\_\_

Main Complaint \_\_\_\_\_

### CHIEF COMPLAINT

What would you describe your sleep as? (Please check the appropriate items).

- |   |   |
|---|---|
| <input type="checkbox"/> Difficulty in falling asleep | <input type="checkbox"/> Waking up too early                      |
| <input type="checkbox"/> Difficulty in staying asleep | <input type="checkbox"/> Difficulty staying awake during day time |
| <input type="checkbox"/> Nightmare/ Unusual dreams    | <input type="checkbox"/> Unusual movements during sleep           |
| <input type="checkbox"/> Sleep walking                | <input type="checkbox"/> Unrefreshed sleep                        |
| <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Bed wetting                              |

### SLEEP/ DAY SCHEDULE

1. What is your usual bedtime? \_\_\_\_\_ Get up time? \_\_\_\_\_
2. About how many hours do you sleep each night? \_\_\_\_\_
3. How long does it take you to fall asleep? \_\_\_\_\_
4. About how many times do you wake up each night? \_\_\_\_\_
5. How long is your longest wake? \_\_\_\_\_
6. Do you go back to sleep easily after waking in the middle of the night? YES NO
7. What are your work hours? \_\_\_\_\_
8. Do you work variable/ rotating shifts? YES NO  
If so, what are they? \_\_\_\_\_

## SYMPTOMS

1. Is your bed partner disturbed by your sleep problem? YES NO MAYBE
2. Do you feel drowsy or sleepy in any of these situations: (please check appropriate items)
  - Eating meals
  - Watching television
  - Reading
  - Driving
  - Talking in a group
  - In church, watching movie/ theater/ play
3. Does your sleepiness during daytime interfere with your ability to function normally?  
YES NO
4. Have you ever been involved in an automobile accident due to sleepiness while driving?  
YES NO
5. Do you take any naps? YES NO
6. Do you snore? YES NO
7. Have you been told that you do any of these in sleep: (check appropriate items)
  - Stop breathing while sleeping
  - Wake up from sleep snorting or choking
  - Walk in your sleep
  - Grind your teeth
8. Do you wake up in the morning with headaches or dry mouth? YES NO
9. Do you feel fresh in the morning when you wake up? YES NO
10. Do you have any problems with sexual functioning? \_\_\_\_\_
11. Do you experience vivid dream like images while falling asleep or waking from a nap?  
YES NO
12. Do you dream during naps? YES NO
13. Have you ever felt paralyzed while falling asleep or awakening from a nap? YES NO
14. Have you ever had a feeling of weak knees when you laugh? YES NO
15. Do you experience creeping, crawling, or aching sensations in your legs, or inability to keep your legs still? YES NO if so, does it keep you from falling asleep? YES NO
16. Do you watch a clock, watch television, have racing thoughts, or worry about the next day at the time of falling asleep? YES NO
17. Do you exercise before going to sleep? YES NO

**MEDICAL HISTORY**

1. Do you have any of these: (check all that apply)

- High blood pressure
- Asthma/ Emphysema
- Heart attack/ Open heart surgery
- Diabetes
- Cancer
- Epilepsy/ Seizures/ Stroke

2. Do you have any other medical problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

1. How much of these liquids do you drink on a daily basis: (list in cups, cans, etc.)

- \_\_\_\_\_ Coffee
- \_\_\_\_\_ Tea
- \_\_\_\_\_ Soft drinks-caffeinated/ caffeine free
- \_\_\_\_\_ Beer
- \_\_\_\_\_ Wine
- \_\_\_\_\_ Liquor

2. Do you smoke on a regular basis?      YES    NO    If yes, how many packs/day \_\_\_\_\_

**MEDICATION HISTORY**

1. Do you take any medications including over the counter medication to help you fall asleep or stay awake?      YES    NO    If yes, list names: \_\_\_\_\_

2. What is your weight now? \_\_\_\_\_

3. Have you had a significant weight loss/ weight gain?  
Please describe: \_\_\_\_\_

4. What is your height? \_\_\_\_\_

# SLEEPINESS SCALE

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

Please answer how likely you are to doze off or fall asleep in the following situations.  
Use the scale provided below.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

- Sitting and reading \_\_\_\_\_
- Watching TV \_\_\_\_\_
- Sitting inactive in a movie/ meeting \_\_\_\_\_
- Riding in a car as a passenger for more than 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 SCORE = \_\_\_\_\_

Date of test: \_\_\_\_\_

Reference: Epworth Sleepiness Scale