NORTHSTAR
SLEEP CENTER

SLEEP QUESTIONNAIRE

Please fill out this form entirely before your visit.

Sleep Patients:

If you have a CPAP or BiPAP, make sure you bring it or a download to this and every future appointment.

Sleep Chart:

Please record your sleep habits for at least two weeks prior to your evaluation. For each night make a vertical line at the time you went to bed and at the time you got out of bed. Then draw a horizontal line connecting the two. In the two columns at the right, indicate the number of hours in bed, and the number of hours you think you slept.

	Noon	PM											Mid	AM											Hours In Bed	Hours Asleep
Date	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11		

*****Have you ever had a sleep study, if so where and when? ______________________________

********Please bring a copy of any past sleep studies.********

1. Duration/History of Sleep Problem

What is the primary complaint(s), you can choose more than one:

_____ Difficulty falling asleep
_____ Daytime sleepiness
_____ Restless legs at night
_____ Activity during sleep
______ Difficulty staying asleep
______ Snoring
______ Gasping/choking during sleep
Other: ______________________________________

How long have you had, or have been told about, this problem? ____________________

Does anyone else in your family have a similar problem? ____________________

Did this problem start or get worse at the time of any significant stress, physical injury, or weight gain? ____________________

What have you already tried to reduce your sleep problem? ____________________

Have you tried any sleep medication or aids? ____________________

Any sleep disruptors? (bed partner, children, pets, pain, mattress, etc) ____________________

How do you sleep? (side, back, stomach) ____________________

2. Sleep Schedule (If retired please still complete)

What time do you go to bed on the days that you work? ____________________

What time do you get up on the days that you work? ____________________

What time do you go to bed on the days that you don't work? ____________________

What time do you get up on the days that you don't work? ____________________

How many hours do you sleep on the days that you work? ____________ hours

How many hours do you sleep on the days that you don't work? ____________ hours

How long does it take you to fall asleep? ____________ mins

How many times do you (on average) wake up a night? ____________________

How long does it take you to fall back asleep? ____________ mins

How many hours are you in bed? ____________ hours

How many of those are do you think you are actually asleep? ____________ hours

Do you work rotating shifts? ________________ If yes, what shifts? ______________________

Do you take naps? YES NO If yes: Nap time ________ Nap length _________

Do you feel refreshed after naps? YES NO

3. **While Trying to Fall Asleep**

How often do you, or are told that you.... *(Please circle response)*	**Never**	**Sometimes**	**Almost Always**
Have mind racing?	1	2	3
Worry about not falling asleep?	1	2	3
Experience being awake, but being unable to move?	1	2	3
Experience restless legs?	1	2	3

4. **While Asleep or in Bed**

How often do you, or are told that you.... *(Please circle response)*	**Never**	**Sometimes**	**Almost Always**
Awaken frequently from sleep?	1	2	3
Snore?	1	2	3
Stop breathing?	1	2	3
Awaken due to coughing, heartburn or regurgitation?	1	2	3
Grind your teeth?	1	2	3
Sleep walk?	1	2	3
Sleep talk?	1	2	3
Have nightmares?	1	2	3
Wake up to use the bathroom more than once a night?	1	2	3
Thrash or have sudden violent body movements?	1	2	3
Experience dreamlike scenes or hallucinations?	1	2	3
Have night sweats?	1	2	3
Experience nasal congestion?	1	2	3
Experience seizures?	1	2	3
Experience heart palpitations?	1	2	3
Sleep eat?	1	2	3
Sleep kick?	1	2	3
Act out dreams?	1	2	3
Experience vivid dreams?	1	2	3

5. **During Waking Hours**

How often do you, or are told that you.... *(Please circle response)*	**Never**	**Sometimes**	**Almost Always**
Wake up refreshed?	1	2	3
Wake up with morning dry mouth?	1	2	3
Wake up with morning headaches?	1	2	3
Wake up with morning bad breath?	1	2	3
Wake up with morning sore throat?	1	2	3
Experience fatigue?	1	2	3
Experience memory problems?	1	2	3
Experience excessive sleepiness?	1	2	3
Experience sudden muscle weakness or feel as if you might fall down when angry or laughing?	1	2	3
Are irritable?	1	2	3
Are depressed?	1	2	3
Are anxious?	1	2	3
Are hyperactive?	1	2	3
Have problems concentrating?	1	2	3
Fall asleep when or where you should not?	1	2	3

6. **Epworth Sleepiness Scale**

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 imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	________
Watching television	________
Sitting inactive in a public place (i.e. – movie, meeting)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon	________
Sitting talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
Please Total your score	________

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