FOX VALLEY PULMONARY MEDICINE
LUNG DISEASE • INTENSIVE CARE MEDICINE • SLEEP DISORDERS

SLEEP QUESTIONNAIRE

Please fill out this form to the best of your ability and bring the form along with you to your consultation and/or sleep study. Feel free to ask your bed partner or a family member to answer those questions you can not.

NAME:___________________________DATE OF BIRTH:_________________ AGE:___________
FAMILY PHYSICIAN_______________________________________ DATE:__________________
HEIGHT:_______________________________ WEIGHT:_________________________________

1.) Briefly describe your sleep problem:____
____

2.) How long have you had this problem?____

3.) Are you a shift worker? YES______ NO______
If you are a shift worker, please describe your shift(s)____
____

4.) What time do you usually try to go to bed?______________ A.M. / P.M.
Earliest time?__________ Latest time?___________

5.) On average, how long does it typically take you to fall asleep?_____________ MIN/HR

6.) When falling asleep, do you experience the following?

(CHECK ONE BOX FOR EACH STATEMENT)	**NEVER**	**SOMETIMES**	**OFTEN**
a.) Have thoughts racing through your mind?………	_____	_____	_____
b.) Feel sad or depressed?...................................	_____	_____	_____
c.) Have anxiety (worry about things?)………………	_____	_____	_____
d.) Feel muscular tension?...................................	_____	_____	_____
e.) Feel afraid of not being able to sleep?............	_____	_____	_____
f.) Feel like you're unable to move?....................	_____	_____	_____
g.) Have creeping, crawling, or aching feelings in your legs? (feel like you have to move them)…	_____	_____	_____
h.) Have vivid, dream-like scenes even though you know you are not totally asleep?..............	_____	_____	_____
i.) Have any kind of pain or discomfort?..............	_____	_____	_____
j.) Feel afraid of the dark or anything else?..........	_____	_____	_____

7.) How many times do you usually awaken at night?______________________________
How long might you be awake each time?______________________________

8.) If you awaken during the night, is it usually during the:
First half of the sleep period? ______
Second half of the sleep period? ______
Both, or no particular pattern? ______

9.) While you sleep, how often do you….?

(CHECK ONE FOR EACH STATEMENT)	NEVER	SOMETIMES	OFTEN
a.) Snore loudly?.................................... (Please have your bed partner help you answer)	_____	_____	_____
b.) Have pauses in your breathing (apnea) while asleep?.......................	_____	_____	_____
c.) Sleep with someone else in your bed?	_____	_____	_____
d.) Get out of bed at night?...................	_____	_____	_____
If you do, why?____			
e.) Walk in your sleep?............................	_____	_____	_____
f.) Fall out of bed at night?.....................	_____	_____	_____
g.) Wake up at night screaming, violent, or confused?......................................	_____	_____	_____
h.) Feel your heart pounding during the night?..	_____	_____	_____
i.) Sweat a lot during the night?...............	_____	_____	_____
j.) Have unusual movements while asleep?	_____	_____	_____
k.) Wet the bed?..	_____	_____	_____
l.) Wake up choking, wheezing, or have shortness of breath?.............................	_____	_____	_____
m.) Have restless, disturbed sleep?..............	_____	_____	_____

If your sleep is restless and/or disturbed, please describe what causes the restlessness and/or disturbance.____

____

10.) What time do you usually get up?______________ A.M./P.M.

Earliest time? ________A.M./P.M   Latest time? __________A.M./P.M.

11.) About how many hours of actual sleep do you get each night? Hours____Minutes____

12.) When you awaken, how often do you?

(CHECK ONE FOR EACH STATEMENT)	NEVER	SOMETIMES	OFTEN
a.) Depend on an alarm to wake up?................	_____	_____	_____
b.) "Sleep in" in the morning (more than 1 hour past your usual wake-up time)……….	_____	_____	_____
c.) Have a very hard time waking up?................	_____	_____	_____
d.) Feel unable to move when waking up?.........	_____	_____	_____
e.) Have dream-like images when waking up even though you are not asleep?………….	_____	_____	_____
f.) Wake up confused or disorientated?...........	_____	_____	_____
g.) Wake up with a headache?..........................	_____	_____	_____
h.) Wake up nauseous (Sick to your stomach?)..	_____	_____	_____
i.) Have a bad taste in your mouth or have heartburn? ………………………………………………	_____	_____	_____

13.) How many naps do you take in a usual week? ______________________________________

How long are you usually asleep during a nap? ______________________________________

Are the naps refreshing? YES____ NO____

14.) How often do you?

(CHECK ONE FOR EACH STATEMENT)	NEVER	SOMETIMES	OFTEN
a.) Feel fatigued during the day?...................	_____	_____	_____
b.) Feel sleepy during the day?.....................	_____	_____	_____
c.) Fall asleep unintentionally? ………………….	_____	_____	_____
d.) Feel sad or depressed? ………………………..	_____	_____	_____
e.) Have anxiety (worry about things)?………..	_____	_____	_____
f.) Feel muscular tension?............................	_____	_____	_____
g.) Have thoughts racing through your mind?	_____	_____	_____
h.) Feel weakness in your muscles when laughing, surprised, angry, or excited?....	_____	_____	_____

15.) How much of the following do you drink?

Caffeinated coffee….._____cups per day   Beer……………._____cans per day

Tea………………………….._____cups per day   Wine……………._____glasses per day

Soda………………………._____cans per day   Other alcohol..._____drinks per day

16.) What beverages do you usually drink within two hours of going to bed?

____

17.) Do you smoke? YES_____ NO_____

What do you smoke? Cigarettes_____ Cigars_____ Pipe_____

How much do you smoke in a 24 hours period? ______________________________________

How long have you been smoking? Years________

18.) Allergies? YES_____ NO_____

19.) How many times each week do you participate in a sport or partake in some form of exercise?

____

20.) What prescription medications do you take?

____

____

21.) What over the counter medications do you take?____

____

22.) Please list the name of any prescription or non-prescription sleeping pill you have taken in the past:____

____

23.) Do any of your relatives have a sleep problem? If so, please describe:____

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24.) What is your **personal** interpretation as to why you have your particular sleep/wake problem?

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25.) Please have your spouse, family member, significant other, or any other person who is aware of your sleeping problem add additional comments below:

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