

SLEEP QUESTIONNAIRE



TRI-STATE SLEEP DISORDERS CENTER

www.tristatesleep.com

Tri-County Location
1275 E. Kemper Road
Cincinnati, OH 45246
(513) 671-3101



Tri-State Sleep Disorders Center

SLEEP QUESTIONNAIRE

NAME: TELEPHONE (HOME)

ADDRESS: TELEPHONE (WORK)

(CITY) (STATE) (ZIP CODE)

FAMILY PHYSICIAN

(CITY) (STATE) (ZIP CODE)

My main sleep complaint is:

- Trouble sleeping at night
- Being sleepy all day
- Snoring
- Unwanted behaviors during sleep

Explain:

Current Medical conditions for which I am being treated are:

Medications I am currently taking are:



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SLEEP HABITS

On weekdays (work days) I usually go to bed at:

On weekdays I wake up at:

How many days a week do you take a nap?

The amount of time that I usually take to fall asleep is:

The number of times that I usually wake up during the night is:

If I wake up during the night, the time it usually takes me to fall asleep again is:

My total sleep time per night is:

Place a check beside any of the following statements that are true:

- I have a job that involves shift work or night work.
- I frequently travel across time zones (east-west travel)
- I feel that sleep is a waste of time.
- I enjoy sleeping very much.
- I usually sleep with a bed partner.
- I sleep with earplugs or eye shades.

During the first 30 minutes after waking up in the morning, I usually feel:

- Very groggy
- Somewhat drowsy
- Slightly drowsy but awake.
- Alert



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DAYTIME SLEEPINESS

- I have sometimes fallen asleep at very inappropriate times, such as driving, eating, or during a conversation.
- I have sometimes been so sleepy that I become confused or lose track of the topic during a conversation.
- I am frequently so sleepy during the day that my work is poor.
- I have had accidents or near accidents when driving because I felt so sleepy.
- I frequently do not feel sleepy at bedtime and stay up until it is so late that as a consequence I get too little sleep.
- I would feel better if I slept at least one more hour every night.
- I feel that I sleep too much.
- I feel that I sleep too little.
- I function best in the morning.
- I function best in the evening.
- I've "come to" or suddenly become alert and found myself doing things without being aware of having started them or how I got there.
- I generally feel tired all day.
- I generally feel sleepy all day.
- When I get a good night sleep I feel better the next day.
- Several times recently I got up later than planned, even though I went to bed at the right time.
- Usually I find myself falling asleep during even half-hour T.V. shows.
- Sometimes I perform a complex act such as driving a car to the wrong destination and not remembering how I did it.
- I sometimes find myself doing things that make no sense (such as writing nonsense or mixing chocolate with gravy).
- I've had the sensation of a sudden weakness in my legs while awake (this may occur particularly in emotional situations, such as laughter, anger, etc.)



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- I sometimes have felt paralyzed or unable to move when waking up or falling asleep.
- I have hallucinations or dream-like images when I am not actually asleep but while falling asleep or waking up.

PARASOMIAS

Place a check beside any of the following statements that are true for you:

- I have been told that I grind my teeth when I sleep.
- As an adolescent or adult, I have been seen sleepwalking.
- As an adolescent or adult, I have been seen sleeptalking.
- My dreams are often very vivid.
- I feel that I dream too much.
- My dreams often awaken me.
- I often have frightening dreams.
- As an adult I have wet my bed.
- I've been told that I bang or twist my head at night.

DISTURBED SLEEP

Place a check beside any of the following statements that are true of you:

- I have been told that I snore very loudly.
- Sometimes a person cannot sleep in the same room with me because he or she is bothered by my snoring.
- My bed covers are very messed up in the morning.
- I am a very restless sleeper.
- I have been told that I kick or poke my bed partner while I am asleep.
- I sometimes wake up with a choking sensation.
- I've been told that I stop breathing when I sleep.
- I have fallen out of bed.



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- I have been told that I make a rolling or rocking movements during sleep.
- I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension, or unhappiness.
- I have awakened from sleep once or more having vomited.
- When I wake during the night, I often have to get up and go to the bathroom.
- I sweat a lot when I sleep.
- I feel that the quality of my sleep is unsatisfactory.
- I have been told that my legs twitch or jerk while I am sleeping.
- I sometimes wake up with a headache.
- I sometimes have pain from my heart during the night.
- I usually have a bitter or sour taste in my mouth when I awaken at night or in the morning.

INSOMNIA

Place a check beside any of the following statements that are true for you:

- I have trouble falling asleep at night.
- When I don't sleep well, I worry about it the next day.
- When I wake up during the night, I have trouble going back to sleep.
- I wake up in the morning long before I have to.
- Some nights, I never get to sleep no matter how hard I try
- When I try to go to sleep, my mind races with many thoughts.
- At night when I go to bed I don't feel sleepy.
- I often sleep better in an unfamiliar bedroom, such as a hotel or motel room.
- When I try to fall asleep I become anxious or nervous.
- When I try to fall asleep I worry about whether or not I can sleep.
- When I try to fall asleep I often feel hungry or thirsty.



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- When I try to fall asleep I feel pain.
- Pain often wakes me up or keeps me from going back to sleep.
- I often take sleeping pills in order to sleep.
- I have a creeping, crawling sensation in my legs when I lie down to sleep.
- When I do sleep, I feel that I sleep very well.
- I am a very light sleeper; I am easily awakened by noises.
- My sleep is disturbed because of my bed partner.
- Heat or cold disturbs my sleep.
- Generally I get up in the middle of the night for a snack.

MEDICAL CONDITIONS

Place a check beside any of the following statements that are true for you:

- I have been told that I shake my head at night.
- I have been told that I have convulsions, fits, or seizures at night.
- I have had convulsions, fits, or seizures during the day.
- I have bitten my tongue while asleep.
- I sometimes wake up with heartburn.
- I sometimes wake up with lower back pain.
- I sometimes wake up with feelings of aching or “pins and needles” in my legs.
- I sometimes am unable to sleep in a flat position because of shortness of breath.
- I sometimes cough up sputum or mucus during the night or in the morning.
- I have gained more than 10 lbs. in the last year.
- I have lost more than 10 lbs. in the last year.
- I have been told that I have high blood pressure.



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- I rarely drink alcoholic beverages.
- I consume the following:

	Weekdays	Weekend days
bottles or cans of beer	_____	_____
glasses of wine	_____	_____
shots of liquor	_____	_____

- I use alcohol in order to get to sleep: sometimes often

MEN

- I awaken with painful penile erections.
- I have problems obtaining or maintaining penile erection.

WOMEN

- My sleep problem varies according to the stage of my menstrual cycle.
- I am currently taking birth control pills.
- My sleep problem started and got worse at menopause.

SLEEP HISTORY

Place a check beside any of the following statements that are true for you. (If possible, please ask your parents or older siblings to help you remember your childhood behavior).

- I sometimes wet the bed after age 6
- As a child I talked in my sleep.
- As a child I sleepwalked
- As a child I had frequent nightmares.
- As a child I screamed in my sleep.
- As a child I had convulsions during sleep.
- As a child I banged or rocked my head on the bed to sleep.
- My current sleep problem started in childhood.



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- I used to fall asleep in school as a child or adolescent.
- I always had to fight the urge to sleep during my classes at school when I was a child adolescent.
- As a child I used to stay up late in the evening.
- I was told that I snored while sleeping as a child or teenager.
- I was considered a hyperactive or hyperkinetic child or teenager.

FAMILY HISTORY

(These questions apply to you extended family: parents, children, aunts, uncles, cousins, nieces, nephews, etc. -relatives related by "blood").

- A relative died from "crib death" or SIDS (sudden infant death syndrome).
- Other members of my family have insomnia
- Other members of my family snore loudly at night.
- Other members of my family frequently fall asleep during the day or evening.
- Other members of my family are troubled by sudden attacks of physical weakness or paralysis, particularly in emotional situations.
- Other members of my family have been hyperactive or hyperkinetic as children
- Other members of my family have the same sleep problem that I do.

ALLERGIES

- None
- Medications
- Other

HABITS

- Cigarettes _____ Pack(s) per day for _____ years
_____ Former smoker (_____ Pack(s) per day for _____ years)
- Marijuana
- Other substance(s)



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REVIEW OF BODY SYSTEMS

(please circle any symptoms or problems that might apply to you)
(please add anything that applies to you that we've left out)

- Constitutional: fatigue, loss of energy, feel ill, appetite change, fever, chills, unplanned weight change
- Eyes: vision changes, new eye pain, blind spots, cataracts
- Ears, Nose, Throat, Mouth: hearing problems, ringing in ears, nose bleeds, nasal congestion, nasal discharge, sinus pain or pressure, sore throat, hoarseness, dental problems, jaw pain
- Cardiovascular: high blood pressure, chest pressure or pain, heavy sweats, ankle swelling, heart murmurs, irregular beats, shortness of breath with exercise, abrupt episodes of shortness of breath without exercise or when lying down, low blood pressure
- Respiratory: shortness of breath, cough, coughing up blood, coughing up phlegm, asthma or wheezing, use two or more pillows to sleep, emphysema
- Gastrointestinal: abdominal pain, heartburn, trouble swallowing, nausea, vomiting, diarrhea, constipation, jaundice, blood in stools, dark or black stools, change in abdominal size, ulcers, hemorrhoids
- Genitourinary: urinary urgency, urinary frequency, pain on urination, blood in urine, awakenings to urinate, kidney stones, prostate problems, leak urine when you cough, sneeze or laugh, menopause
- Musculoskeletal: muscle pain, joint pain, joint swelling, bone pain, injuries, back problems, neck problems
- Skin/Breasts: rash, itching, new skin lesions, leg ulcers, lumps, tenderness, nipple discharge
- Neurologic: tingling, numbness, incoordination, balance problems, seizures, passing out, episodic or chronic muscle weakness or paralysis, severe or chronic headache, dizziness, history of stroke
- Psychiatric: anxiety, agitation, irritability, depression, mood changes, hallucinations, delusions, delirium, dementia
- Endocrine: diabetes, weight change, frequent urination, excessive thirst, thyroid problems, cold intolerance, heat intolerance, hair loss, high cholesterol, high triglycerides
- Hematologic/lymphatic: anemia, polycythemia, bleeding gums, unusual bruising, swollen lymph glands
- Allergic/immunologic: recurrent infections, hives, seasonal allergies, drug allergies

Other symptoms experienced: _____



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EPWORTH SLEEPINESS SCALE (ESS)

Name: _____

Today's Date ____/____/____

Your Age (YEARS) _____

Your Sex (M or F)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. **Use the following scale to choose the best number for each situation:**

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation

Chance of Dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (e.g., a theater or meeting) _____

Sitting as a passenger in a car, for an hour without a break _____

Lying down to rest in the afternoon when your schedule permits it _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

Sitting in a car, while stopped for a few minutes in the traffic _____



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FATIGUE SEVERITY SCALE (FSS)

Name: _____

Today's Date ____/____/____

Your Age (YEARS) _____

Your Sex (M or F)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains 9 statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

A low value (e.g., 1) indicates strong disagreement with the statement, whereas, a high value (e.g. 7) indicates strong agreement.

It is important that you circle a number (1 to 7) for every question.

During the past week, I have found that:	Disagree	Agree
1. My motivation is lower when I am fatigued.	1	2 3 4 5 6 7
2. Exercise brings on fatigue.	1	2 3 4 5 6 7
3. I am easily fatigued.	1	2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1	2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1	2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1	2 3 4 5 6 7
7. Fatigue interferes with carrying out certain responsibilities.	1	2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1	2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1	2 3 4 5 6 7

TOTAL SCORE: _____



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SYMPTOM INTENSITY SCALE (SIS)

Name: _____

Today's Date ____/____/____

Your Age (YEARS) _____

Your Sex (M or F)

Please indicate any areas of pain in the past 7 days

AREAS	YES	NO	AREAS	YES	NO
Jaw (left)			Upper arm (left)		
Jaw (right)			Upper arm (right)		
Chest			Upper back		
Abdomen			Hip (left)		
Forearm (left)			Hip (right)		
Forearm (right)			Shoulder (left)		
Upper leg (left)			Shoulder (right)		
Upper leg (right)			Neck		
Lower Leg (left)			Low back		
Lower Leg (right)					

Total number of painful areas: _____

Please indicate your current level of fatigue by drawing a straight line that reflects how much fatigue you feel.

No fatigue	-----	Very Fatigued
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ZDS SCALE

Name: _____

Date ____/____/____

Please read each statement and decide how much of the time the statement describes how you've been feeling during the past week. Respond to all statements.

Please Make an (X) in the appropriate column	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Score: _____



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ZAS SCALE

Name: _____

Date ____ / ____ / ____

Please read each statement and decide how much of the time the statement describes how you've been feeling during the past week. Respond to all statements.

Please Make an (X) in the appropriate column	None or a little of the time	Some of the time	Good part of the time	Most of the time
1. I feel more nervous and anxious than usual.				
2. I feel afraid for no reason at all.				
3. I get upset easily or feel panicky.				
4. I feel like I'm falling apart or going to pieces.				
5. I feel that everything is all right and nothing bad will happen.				
6. My arms and legs shake and tremble.				
7. I am bothered by headaches, neck and back pains.				
8. I feel weak and get tired easily.				
9. I feel calm and can sit still easily.				
10. I can feel my heart beating fast.				
11. I am bothered by dizzy spells.				
12. I have fainting spells or feel like it.				
13. I can breathe in and out easily.				
14. I get feelings of numbness and tingling in my fingers, toes.				
15. I am bothered by stomach aches or indigestion.				
16. I have to empty my bladder often.				
17. My hands are usually warm and dry.				
18. My face gets hot and blushes.				
19. I fall asleep easily and get a good night's rest.				
20. I have nightmares				

Score: _____