

SUTTER SLEEP DISORDERS CENTER

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PATIENT SLEEP QUESTIONNAIRE

Patient Name: _____

Address: _____

Home Ph: _____

Cell Ph: _____

Wk Ph: _____

Date: _____

HT: _____ WT: _____

MAIN SLEEP COMPLAINT: _____

Duration: _____ Frequency: _____ Severity: _____

MEDICAL ILLNESSES: _____

MEDICATIONS: _____

SOCIAL: Single Married Separated Divorced Widowed

ALCOHOL: Never Rarely (1-2 drinks/wk) Moderately (3-10 drinks/wk)

TOBACCO: Don't smoke _____ Smoke cigarettes _____ Packs per day _____

Used to smoke _____ years but quit _____ years ago.

COFFEE, TEA, COLA: _____ cups per day

SLEEP COMPLAINT (s)

_____ Trouble sleeping at night – frequent awakenings

_____ Trouble initiating sleep

SLEEP COMPLAINT (s) CONTINUED

_____ Trouble awakening early

_____ Snoring

_____ Unwanted behaviors when asleep; explain: _____

SLEEP SCHEDULE

On weekdays (workdays) usual bedtime: _____

On weekdays (workdays) the earliest time in the last 2 weeks having gone to bed is: _____

On weekdays (workdays) the latest time in the last 2 weeks having gone to bed is: _____

In the evening usual time start feeling sleep at: _____

The amount of time that it usually takes to fall asleep: _____

On weekdays (workdays), time usually wake up at: _____

On weekends (off days) usual bedtime: _____

On weekends (off days) usual wake up time: _____

To feel his/her best, number of hours of sleep are: _____

The number of times awakened during the night is usually: _____

The clock times at which awakened during the night are: _____

The amount of time it takes to go back to sleep: _____

Number of times to arise to urinate per night: _____

Awakened in the morning _____ Naturally _____ Using an alarm (s) _____

Usual number of days he/she naps per week: _____

After taking a nap usually feels (check one):

_____ refreshed _____ groggy or sleepy

SLEEP COMPLAINT (s) CONTINUED

Usually exercise at _____ o'clock for _____ minutes.

WORK AND WORK SCHEDULE

Occupation: _____

Usual work hours:

_____ Day shift (hours _____ to _____)

_____ Evening shift (hours _____ to _____)

_____ Night shift (hours _____ to _____)

_____ Rotate shifts (every _____ days)

Comments: _____

Commuting to and from work takes _____ minutes.

_____ He/She sometimes flies across time zones. How often ? _____

How many time zones? _____

SLEEP CHARACTERISTICS

Place a check beside any of the statements which are true:

_____ Snores very loud (heard greater than 1 room away).

_____ A person cannot sleep in the same room as him/her because of snoring.

_____ Noted to stop breathing when asleep.

_____ Perspires when asleep.

_____ Restless sleeper.

_____ Awakens with headaches.

_____ Troubling dreams on a recurrent basis.

SLEEP CHARACTERISTICS CONTINUED

Usual sleep position:

_____ Back _____ Side _____ Stomach _____ No single position is usual

_____ Quality of sleep is satisfactory.

_____ Legs twitch or jerk while sleeping.

_____ Makes rolling or rocking movements during sleep.

_____ Kicked or poked my bed partner while asleep.

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

_____ very groggy.

_____ somewhat drowsy.

_____ slightly drowsy.

_____ slightly drowsy, but awake.

_____ alert.

As an Adult:

_____ Dreams often wake patient.

_____ Often have frightening dreams.

_____ Enuresis

_____ Bangs or twists head at night.

_____ Hallucinations or dreamlike images when not actually asleep but while falling asleep.

_____ Sometimes feel paralyzed or unable to move when waking up or falling asleep.

_____ Wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness.

SLEEP CHARACTERISTICS CONTINUED

_____ Sensation of a sudden weakness in legs while awake which may occur particularly in emotional situations.

INSOMNIA

_____ Have trouble falling asleep at night.

_____ When awakened during the night, has trouble going back to sleep.

_____ Some nights he/she never get to sleep.

_____ When trying to fall asleep he/she worries about whether sleep will occur.

_____ When trying to go to sleep his/her mind races with many thoughts.

_____ At night when in bed he/she doesn't feel sleepy.

_____ Often he/she sleeps better in an unfamiliar bedroom, such as a hotel or motel.

_____ When awakened at night, he/she often watches the clock.

_____ Awakens in the morning long before he/she has to.

_____ Pain often causes arousals or prevents going back to sleep; Location of pain _____
_____)

_____ Often takes sleeping pills to fall asleep.

_____ Has creepy, crawly sensation in legs when lying down to sleep.

_____ Sensation in legs keep from falling asleep.

_____ Very light sleeper; easily awakened by noises.

_____ Sleep is disturbed because of bed partner.

_____ Generally awakes in the middle of the night for a snack.

_____ Has been depressed in the past.

_____ Has been hospitalized for depression in the past.

INSOMNIA CONTINUED

- _____ Has had nervous breakdown in the past.
- _____ Tends to be sad or depressed in the winter.
- _____ Tends to be a “night person”.
- _____ Tends to be a “morning person”.

SLEEP HISTORY

- _____ Sometimes wet the bed after the age of 6.
- _____ Walked in sleep as a child.
- _____ Had frequent nightmares as a child.
- _____ Screamed in sleep as a child.
- _____ Teeth grinding during sleep as a child.
- _____ Current sleep problem started in childhood.
- _____ Regularly fell asleep in school as a child or adolescent.
- _____ Used to stay up late in the evening as a child.
- _____ Snored while asleep as a child or teenager.
- _____ Sleepwalking occurred as an adolescent or adult.
- _____ Hyperactive or hyperkinetic child or teenager.

FAMILY HISTORY

These questions apply to extended family; parents, children, aunts, uncles, cousins, nieces, nephews, etc. – relatives related by blood.)

- _____ Other member of family have been hyperactive or hyperkinetic as children.
- _____ Other member of the family have narcolepsy.

DAYTIME SLEEPINESS

- _____ Fall asleep at very inappropriate times such as while in a meeting.
- _____ Sometimes has been so sleepy that became confused or lost track of the topic during a conversation.
- _____ Falls asleep during even half-hour television shows.
- _____ Frequently so sleepy during the day that my work is poor.
- _____ Generally feels most tired (sleepy) in the afternoon.
- _____ Often would like to take an afternoon nap.
- _____ Often has to “fight” sleep while driving, especially on long trips.
- _____ Has had near-accidents when driving because of sleepy sensation.
- _____ Has suddenly become alert and found self doing things without being aware of having started them.
- _____ Generally feels sleepy all day.
- _____ Functions best in the morning.
- _____ Functions best in the evening.
- _____ Frequently does not feel sleepy at bedtime and stays up until it is so late that as a consequence, gets too little sleep.
- _____ When gets a good night sleep, feels better the next day.
- _____ Would feel better if slept at least one more hour every night.
- _____ Would like to sleep later in the morning.
- _____ Feels that sleep time is too short.

What influences have motivated you to seek medical consultation, testing or treatment for your sleep/daytime tiredness concerns? (Check all that apply.)

- AWAKE (Sleep Apnea Support Group)
- TV/Magazine infomercial
- Radio Ad
- Sutter literature/presentation
- Other
- Primary care physician
- Spouse/friend
- Employer
- Dentist