Sutter Health
Sutter Sleep Disorders Center

Insomnia Sleep Questionnaire

Name: ______________________________ Date of Study: ______________

If under 18, Parent/Guardian Name ______________________________

Date of Birth: ____________ Age: ______ Height: ________ Weight: ____________

Referring Physician: ______________________________ Phone #: ______________

Referring Physician's Address: ______________________________

Primary Physician: ______________________________ Phone #: ______________

Primary Physician's Address: ______________________________

Chief 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.

Caffeine: ☐ No ☐ Yes (coffee, tea, cola) / ___________ cups per day

SLEEP COMPLAINT(S)

Trouble sleeping at night – frequent awakenings ☐ Yes ☐ No

Trouble initiating sleep ☐ Yes ☐ No

Trouble awakening early ☐ Yes ☐ No

Snoring ☐ Yes ☐ No

Unwanted behaviors when asleep ☐ Yes ☐ No

If yes, please 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

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. ☐ Yes ☐ No

If yes, how often ? ____________ How many time zones? ______

SLEEP CHARACTERISTICS

Place a check any of the statements which are true:

☐ Perspires when asleep. ☐ Awakens with headaches.

☐ Restless sleeper. ☐ Troubling dreams on a recurrent basis.

☐ Noted to stop breathing when asleep. ☐ Snores very loud (heard greater than 1 room away).

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

Usual sleep position: ☐ Back ☐ Side ☐ Stomach ☐ No single position is usual

Quality of sleep is satisfactory. ☐ Yes ☐ No

Legs twitch or jerk while sleeping. ☐ Yes ☐ No

Makes rolling or rocking movements during sleep. ☐ Yes ☐ No

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Kicked or poked my bed partner while asleep. ☐ Yes ☐ No

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

☐ very groggy ☐ somewhat drowsy ☐ slightly drowsy, but awake
☐ slightly drowsy ☐ alert

As an Adult:

Dreams often wake patient. ☐ Yes ☐ No

Often have frightening dreams. ☐ Yes ☐ No

Enuresis ☐ Yes ☐ No

Bangs or twists head at night. ☐ Yes ☐ No

Hallucinations or dream-like images when not actually asleep but while falling asleep. ☐ Yes ☐ No

Sometimes feel paralyzed or unable to move when waking up or falling asleep. ☐ Yes ☐ No

Wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness. ☐ Yes ☐ No

Sensation of a sudden weakness in legs while awake which may occur particularly in emotional situations. ☐ Yes ☐ No

INSOMNIA

Have trouble falling asleep at night. ☐ Yes ☐ No

When awakened during the night, has trouble going back to sleep. ☐ Yes ☐ No

Some nights he/she never get to sleep. ☐ Yes ☐ No

When trying to fall asleep he/she worries about whether sleep will occur. ☐ Yes ☐ No

When trying to go to sleep his/her mind races with many thoughts. ☐ Yes ☐ No

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At night when in bed he/she doesn't feel sleepy.	☐ Yes	☐ No
Often he/she sleeps better in an unfamiliar bedroom, such as a hotel or motel.	☐ Yes	☐ No
When awakened at night, he/she often watches the clock.	☐ Yes	☐ No
Awakens in the morning long before he/she has to.	☐ Yes	☐ No
Pain often causes arousals or prevents going back to sleep.	☐ Yes	☐ No

If yes, location of pain ____

Often takes sleeping pills to fall asleep.	☐ Yes	☐ No
Has creepy, crawly sensation in legs when lying down to sleep.	☐ Yes	☐ No
Sensation in legs keep from falling asleep.	☐ Yes	☐ No
Very light sleeper; easily awakened by noises.	☐ Yes	☐ No
Sleep is disturbed because of bed partner.	☐ Yes	☐ No
Generally awakes in the middle of the night for a snack.	☐ Yes	☐ No
Has been depressed in the past.	☐ Yes	☐ No
Has been hospitalized for depression in the past.	☐ Yes	☐ No
Has had nervous breakdown in the past.	☐ Yes	☐ No
Tends to be sad or depressed in the winter.	☐ Yes	☐ No
Tends to be a "night person".	☐ Yes	☐ No
Tends to be a "morning person".	☐ Yes	☐ No

SLEEP HISTORY

Sometimes wet the bed after the age of 6.	☐ Yes	☐ No
Walked in sleep as a child.	☐ Yes	☐ No
Had frequent nightmares as a child.	☐ Yes	☐ No

Screamed in sleep as a child.	☐ Yes	☐ No
Teeth grinding during sleep as a child.	☐ Yes	☐ No
Current sleep problem started in childhood.	☐ Yes	☐ No
Regularly fell asleep in school as a child or adolescent.	☐ Yes	☐ No
Used to stay up late in the evening as a child.	☐ Yes	☐ No
Snored while asleep as a child or teenager.	☐ Yes	☐ No
Sleepwalking occurred as an adolescent or adult.	☐ Yes	☐ No
Hyperactive or hyperkinetic child or teenager.	☐ Yes	☐ No

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.	☐ Yes	☐ No
Other member of the family have narcolepsy.	☐ Yes	☐ No

DAYTIME SLEEPINESS

Fall asleep at very inappropriate times such as while in a meeting.	☐ Yes	☐ No
Sometimes has been so sleepy that became confused or lost track of the topic during a conversation.	☐ Yes	☐ No
Falls asleep during even half-hour television shows.	☐ Yes	☐ No
Frequently so sleepy during the day that my work is poor.	☐ Yes	☐ No
Generally feels most tired (sleepy) in the afternoon.	☐ Yes	☐ No
Often would like to take an afternoon nap.	☐ Yes	☐ No

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Often has to “fight” sleep while driving, especially on long trips. ☐ Yes ☐ No

Has had near-accidents when driving because of sleepy sensation. ☐ Yes ☐ No

Has suddenly become alert and found self doing things without being aware of having started them. ☐ Yes ☐ No

Generally feels sleepy all day. ☐ Yes ☐ No

Functions best in the morning. ☐ Yes ☐ No

Functions best in the evening. ☐ Yes ☐ No

Frequently does not feel sleepy at bedtime and stays up until it is so late that as a consequence, gets too little sleep. ☐ Yes ☐ No

When gets a good night sleep, feels better the next day. ☐ Yes ☐ No

Would feel better if slept at least one more hour every night. ☐ Yes ☐ No

Would like to sleep later in the morning. ☐ Yes ☐ No

Feels that sleep time is too short. ☐ Yes ☐ No

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

☐ Primary care physician ☐ TV/Magazine infomercial

☐ Spouse/friend ☐ Radio Ad

☐ Employer ☐ Sutter literature/presentation

☐ Dentist ☐ Other ______________________________

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Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Age (Yrs): __________________ **Gender:** ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? *This refers to your usual way of life in recent times.*

Use the following scale to choose the most appropriate number for each situation:

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

It is important that you answer each question as best you can.

Situation	Chance of Dozing
Sitting and reading	______
Watching TV	______
Sitting, inactive in public place (e.g. a theater or a meeting)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking to someone	______
Sitting quietly after a lunch without alcohol	______
In a car, while stopped for a few minutes in traffic	______

THANK YOU FOR YOUR COOPERATION

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Pre-Sleep Questionnaire

Name: ____________________ **Date of Study:** ____________________

Date of Birth: ______________ **Age:** ________ **Height:** ____________ **Weight:** ____________

1. General Functioning last night

	(bad)				(very good)
Quality of Sleep	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Daytime Energy	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Ability Staying Awake	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Job Performance	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

2. What time did you wake up today? ______________

3. Did you get your normal amount of sleep last night? ☐ **Yes** ☐ **No**

4. Did you have any caffeinated or alcoholic beverages today? ☐ **Yes** ☐ **No**

5. Have you taken your medications today? ☐ **Yes** ☐ **No**

6. Substance use in the last 24 hours/
   - Tranquilizers ☐ **Yes** ☐ **No**
   - Marijuana ☐ **Yes** ☐ **No**
   - Opiates (codeine, MS, heroin) ☐ **Yes** ☐ **No**
   - Alcohol ☐ **Yes** ☐ **No**
   - Amphetamines (cocaine, crack, diet pills) ☐ **Yes** ☐ **No**
   - Tobacco ☐ **Yes** ☐ **No**
   - Hallucinogens (PCP, LSD) ☐ **Yes** ☐ **No**
   - Other: ______________________________

7. Did you do any exercising today? ☐ **Yes** ☐ **No**

8. Have you recently gained weight without trying? ☐ **Yes** ☐ **No**

9. When did you eat your last meal? ______________

10. Any physical complaints today? ☐ **Yes** ☐ **No**

11. Are you in pain right now? ☐ **Yes** ☐ **No**
    If yes, what is the intensity? **0 → 10** ________

12. Are you currently a victim of domestic violence? ☐ **Yes** ☐ **No**