OU Health Sleep Questionnaire

SAVE

Name _____ **DOB**: _____ **Today's Date**: _____

Age: _____ **Gender**: Female **Height**: _____ **Weight**: _____

Best Contact Phone #: _____

Mailing Address: _____

_____

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What is your MAIN problem/issue with sleep? _____

_____

_ How long has it been a problem? _____Weeks _____Months _____Years

Have you been diagnosed with a sleep disorder? **No** ☐ **Sleep Apnea** ☐ **Insomnia** ☐ **Restless Legs**

Other_____

During the past month, how often… (can be based on report of roommate or bed partner)	Never	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week	I do not know
…do you wake with a headache?	☐	☐	☐	☐	☐	☐
…do you wake with a dry mouth?	☐	☐	☐	☐	☐	☐
…do you stop breathing while sleeping?	☐	☐	☐	☐	☐	☐
…do you wake gasping or choking?	☐	☐	☐	☐	☐	☐
…do you snore loudly enough to be noticed?	☐	☐	☐	☐	☐	☐
…do you snore loudly enough that you were told you bothered some else's sleep?	☐	☐	☐	☐	☐	☐
…do you have leg twitching or jerking while you sleep?	☐	☐	☐	☐	☐	☐
…are you BOTHERED by the urge to move your legs for comfort as you fall asleep or sit?	☐	☐	☐	☐	☐	☐
…do you grind/clench your teeth at night?	☐	☐	☐	☐	☐	☐
…do you walk in your sleep?	☐	☐	☐	☐	☐	☐
…do you experience very vivid dreams while falling asleep or waking up?	☐	☐	☐	☐	☐	☐
…are you unable to move while falling asleep or waking up?	☐	☐	☐	☐	☐	☐
…are you unable to move arms or legs when laughing or feeling other strong emotions?	☐	☐	☐	☐	☐	☐
…have you had memories or nightmares of a traumatic experience?	☐	☐	☐	☐	☐	☐
…had episodes of terror or screaming during sleep without fully awakening?	☐	☐	☐	☐	☐	☐
…had episodes of "acting out" your dreams such as kicking, punching, running, or screaming	☐	☐	☐	☐	☐	☐

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How many pounds have you gained since age 20 or entry into the military (whichever is larger)? _____ N/A

Do you currently do night shift work? ☐YES ☐ NO

Have you worked night shift for at least 2 months in the past? ☐ YES ☐ NO

Does your spouse currently perform night shift work? ☐ YES ☐ NO

Do you feel rested after sleeping at night? ☐ YES ☐ NO

Have you had a car accident or near miss due to sleepiness? ☐ YES ☐ NO Year: _____

Bedroom Environment:

Do you have a bed partner? ☐ YES ☐ NO

-If yes, does your sleep disturb their sleep? ☐ YES ☐ NO

- If yes, does their sleep disturb your sleep? ☐ YES ☐ NO

Do you look at the clock at night? ☐ YES ☐ NO

Do you watch TV, eat, read, or use a computer/tablet/cell phone in bed? ☐ YES ☐ NO

Do you sleep with children? ☐ YES ☐ NO

Do you sleep with a pet(s)? ☐ YES ☐ NO

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= **Please select any MEDICAL CONDITIONS you have been diagnosed with:**

☐High Blood Pressure	☐Atrial Fibrillation	☐Coronary Artery Disease	☐Congestive Heart Failure
☐Stroke	☐Asthma	☐COPD	☐ Seizures
☐Fibromyalgia	☐Chronic Pain	☐TMJ Pain	☐Low Back Pain
☐Headaches	☐Seasonal Allergies	☐Bruxism	☐Diabetes Mellitus
☐Depression	☐Anxiety	☐Erectile Dysfunction	☐Reflux Disease (GERD)

Other: _____

Do you have: Traumatic Brain Injury (**TBI**) ☐YES ☐NO Post Traumatic Stress Disorder (PTSD) ☐YES ☐NO

Please list any medication ALLERGIES: _____

Medications (indication) you currently taking to including prescription, over-the-counter, and herbal medications:

Example: Lisinopril (blood pressure) _____

_____

Have you previously taken a sleep aid? ☐YES ☐NO: ☐ Ambien ☐Lunesta ☐Sonata ☐Trazodone ☐Mirtazapine

Other_____

Please select any SURGERIES you have ever had:

☐Tonsillectomy/Adenoidectomy ☐ Nasal Surgery ☐ Jaw Surgery ☐ Gastric Bypass

Other: _____

Do you have a family history of sleep apnea or other sleep disorders? ☐Yes _____ ☐No

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What is your average daily caffeine intake? Sodas_____ Ice tea_____ Coffee _____ Energy drinks _____

Do you drink alcohol? **No** (Please fill in blanks) How many drinks daily? _____Weekly? _____

Have you regularly used tobacco products: ☐No ☐Yes (Please fill in blanks below)

How old were you when you started regularly using tobacco? _____

How old were when you quit? _____ (Please enter N/A if still using)

How many packs / cans (please circle) daily? _____

EPWORTH SLEEPINESS SCALE

This questionnaire - called the Epworth Sleepiness Scale – was developed by Dr. Murray Johns of Melbourne, Australia, to measure daytime sleepiness. The following questions will ask how likely are you to doze off or fall asleep in the certain situations, in contrast to just feeling tired. Using the rating scale below, rate each of the following statements as it best applies to you.

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

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____

Total score (add the numbers up) (This is your Epworth score)	____

© Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. Dec 1991;14(6):540-545.

SAMHS Sleep Disorders Center Questionnaire

INSOMNIA SEVERITY INDEX

1. Please rate the current **SEVERITY** of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very Severe	
Difficulty falling asleep	**0**	**1**	**2**	**3**	**4**	_____
Difficulty staying asleep	**0**	**1**	**2**	**3**	**4**	_____
Problem waking up too early	**0**	**1**	**2**	**3**	**4**	_____

How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied		Moderately satisfied		Very Dissatisfied	
0	**1**	**2**	**3**	**4**	_____

2. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g., daytime functioning, ability to function at work/daily chores, concentration, memory, mood, etc.)?

Not at All	A little	Somewhat	Much	Very much	
0	**1**	**2**	**3**	**4**	_____

3. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at All	A little	Somewhat	Much	Very much	
0	**1**	**2**	**3**	**4**	_____

4. How **WORRIED**/distressed are you about your current sleep problem?

Not at All	A little	Somewhat	Much	Very much	
0	**1**	**2**	**3**	**4**	_____

5. After a poor night's sleep, which of the following problems do you experience the next day? Circle all those that apply.

☐ Daytime fatigue: tired, exhausted, and washed out, sleepy.

☐ Difficulty functioning: performance impairment at work/daily chores, difficulty concentrating, memory problems.

☐ Mood problems: irritable, tense, nervous, groggy, depressed, anxious, grouchy, hostile, angry, confused.

☐ Physical symptoms: muscle aches/pain, light-headed, headache, nausea, heartburn, muscle tension.

☐ None.

© Bastien CH, Vallières A, Morin CM. Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med 2001;2:297-307.

Pittsburgh Sleep Quality Index

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month:

1. What time have you usually gone to bed at night? BED TIME _____
2. How long (in minutes) has it taken to you to fall asleep each night? NUMBER OF MINUTES_____
3. What time have you usually gotten up in the morning? GETTING UP TIME_____
4. A. How many hours of actual sleep did you get at night? _____
   B. How many hours were you in bed? _____

5. During the past month, how often have you had trouble sleeping because you:	Not during the last month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes	☐	☐	☐	☐
B. Wake up in the middle of the night or early morning	☐	☐	☐	☐
C. Have to get up to use the bathroom	☐	☐	☐	☐
D. Cannot breathe comfortably	☐	☐	☐	☐
E. Cough or snore loudly	☐	☐	☐	☐
F. Feel too cold	☐	☐	☐	☐
G. Feel too hot	☐	☐	☐	☐
H. Have a bad dream	☐	☐	☐	☐
I. Have pain	☐	☐	☐	☐
J. Other reason(s), please describe including how often you have had trouble sleeping because of this reason(s): _____ _____	☐	☐	☐	☐
6. During the past month, how often have you taken medicine (prescribed or over the counter) to help you sleep?	☐	☐	☐	☐
7. During the past month, how often have you had trouble staying awake while driving, eating or engaging in social activity?	☐	☐	☐	☐

8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?

☐ Not a problem at all (0) ☐ Only a very slight problem (1) ☐ Somewhat of a problem (2) ☐ A very big problem (3)

9. How would you rate your sleep quality overall?

☐ Very good (0) ☐ Fairly good (1) ☐ Fairly bad (2) ☐ Very bad (3

©Buysse DJ, Reynolds CF, Monk TH, Berman SR, Kupfer DJ: Psychiatry Research, 28:193-213, 1989.