Sleep Questionnaire (page 1 of 3)

Name: ____________________________________________________________

Date: ____________________________________________________________________________

Age: ___________________________________________________________________________

Height/Weight: __________________________ / __________________________

Weight 5 years ago: ____________________________________________________________________________

What time do you usually go to bed? ________________ a.m. / p.m.

What time do you usually wake up? ________________ a.m. / p.m.

How long does it usually take you to fall asleep after deciding to fall asleep? _________ hrs _____ min

How many times do you wake up during a typical night? ____________ times __________ duration

What are the total hours of sleep that you usually get at night?
(Do not count the hours you spend awake in bed at night). ____________ hrs ____________ min

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 No chance of dozing
1 Slight chance of dozing
2 Moderate chance of dozing
3 High chance of dozing

Sitting and reading
Watching TV
Sitting inactive in a 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
Sitting and talking to someone
Sitting quietly after a lunch without alcohol
In a car, while stopped for a few minutes in traffic
Total
Sleep Questionnaire (page 2 of 3)

Please circle the number that most closely corresponds to the degree of frequency that you are bothered by a particular complaint or problem DURING THE PAST MONTH.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>None or Never</td>
<td>Very slight or Rarely</td>
<td>Slight or Seldom</td>
<td>Moderate or Occasionally</td>
<td>Major or Often</td>
<td>Great or Very often</td>
<td>Very Great or Always</td>
<td></td>
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</tbody>
</table>

1 2 3 4 5 6 7 | How often do you fall asleep during the day, particularly when you are still or not busy?  
1 2 3 4 5 6 7 | How great of a problem do you have with non-restorative sleep (that is, no matter how much sleep you get, you don’t wake up feeling rested)?  
1 2 3 4 5 6 7 | Do you suffer from unexplained fatigue during the day?  
1 2 3 4 5 6 7 | How often do you take a nap?  
1 2 3 4 5 6 7 | Do you awaken feeling really sleepy or groggy?  
1 2 3 4 5 6 7 | Do you snore during sleep?  
1 2 3 4 5 6 7 | How often has a bed partner noted you holding or stopping your breathing during sleep?  
1 2 3 4 5 6 7 | Does your spouse sleep separately from you?  
1 2 3 4 5 6 7 | Is your snoring worse on your back?  
1 2 3 4 5 6 7 | How often is your sleep disturbed by other breathing problems?  
1 2 3 4 5 6 7 | Do you suffer from headaches on awakening?  
1 2 3 4 5 6 7 | How often do you awaken because of heartburn or regurgitation (burning in the throat or gagging on stomach contents)?  
1 2 3 4 5 6 7 | How often is your sleep disturbed because of chest pain or angina?  
1 2 3 4 5 6 7 | How great of a problem do you have getting to sleep?  
1 2 3 4 5 6 7 | How great of a problem do you have with waking up from sleep?  
1 2 3 4 5 6 7 | Do you suffer from restless sleep?  
1 2 3 4 5 6 7 | How often has a bed partner noted that your legs twitch or kick in your sleep?
## Sleep Questionnaire (page 3 of 3)

**Please answer to the best of your ability.**
If you would like to make comments or discuss a question further with the doctor, please put a star beside the question.

<table>
<thead>
<tr>
<th>Score</th>
<th>Question</th>
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<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often are you troubled by restless or &quot;creepy&quot; legs in the late evening or at night?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often do you feel unable to move (paralyzed) when just falling asleep or waking up?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often do you have dream-like images (hallucinating people or sounds in the room) when just falling asleep or awaking, even though you know that you are not asleep?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often during the day do you have episodes of sudden muscular weakness when laughing, angry, or in any emotional situation?</td>
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<td>1 2 3 4 5 6 7</td>
<td>How often do you walk in your sleep?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often do you have nightmares (frightening dreams)?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often do you awaken from sleep screaming, violent, or confused?</td>
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<tr>
<td>1 2 3 4 5 6 7</td>
<td>How often is your sleep disturbed by other problems?</td>
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</tbody>
</table>