### SLEEP / WAKE Questionnaire

**SEVEN DAY SLEEP DIARY – PLEASE FILL OUT BEFORE VISIT**

<table>
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<th>Patient Name</th>
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<th>Date of Birth</th>
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**Reports to:**

- Primary Care Physician
- Referring Physician
- Other Physician(s)

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Reason for Referral or Main Sleep Complaint:

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### SLEEP / WAKE Schedule / Ease of Falling Asleep and Staying Asleep:

I begin my bedtime routine at: ____________ AM/PM

I fall asleep in another room prior to retiring to the bedroom; (in front of the TV in the living room, etc):

- [ ] Yes
- [ ] No
- [ ] Sometimes

I am in bed at: ____________ AM/PM

I watch TV or read in bed prior to falling asleep:

- [ ] Yes
- [ ] No
- [ ] Sometimes

I turn out the lights and attempt to sleep at: ____________ AM/PM

It takes me ________ minutes to fall asleep.
SLEEP / WAKE Questionnaire

I wake up __________ times during the night.

Reason for wakening:  ____ Bathroom  ____Thirst  ____Hunger  ____Pain  ____Bed Partner
                     ____ Children  ____Other___________________________________________

Wake up Time: ___________       I wake up naturally:  ____Yes  ____No

I use an Alarm:  ____Yes  ____No       Alarm is set at:  __________

Number of times the snooze alarm is activated: ______

I am out of bed at:_________       I wake up refreshed:  ____Yes  ____No

I nap during waking hours:  ____Never  ____Sometimes  ____Daily

Sleep Environment and Sleep Hygiene

My Sleep Room during hours of sleep:  is comfortable and is suitable to my personal needs:
                     ____Yes  ____No  ____Could be better

My Bed:  is comfortable and suits my sleep style:  ____Yes  ____No....Could be better

There are pets in my room:  ____Yes  ____No

There are children in my room:  ____Yes  ____No

I share my room with a spouse or bed partner:  ____Yes  ____No

My Spouse/bed partner:  Rests comfortably and does not disturb my sleep:
                     ____Yes  ____No  ____N/A

Either due to my schedule or by choice I may be engaged in activities right up to bedtime (work, study, mail, bill paying, entertainment, physical activity):  ____Yes  ____No

Before retiring to bed, I have a routine that permits me to “unwind” and prepare for sleep:
                     ____Yes  ____No
I require specific relaxation techniques to accomplish sleep:  ___Yes   ___No
(readings, meditation, music, prayer, scripture reading, sexual activity, food, beverage, etc)

I require medication to fall asleep:  ___Yes   ___No  ____________________________________________________________

If I wake up during the night, I am able to get back to sleep easily:  ___Yes   ___No
After I wake up, I may get up and ____________________________________________________________

**Sleep related symptoms**

I have experienced or my spouse/family/friends have witnessed:

- Snoring
  - My ___restlessness   ___snoring   ___disruptive sleep disturbs my spouse/bed partner:  ___Yes   ___No   ___N/A
  - My Spouse/bed partner and I: Occasionally sleep separately due to sleep related issues e.g. snoring, restless legs, disruptive sleep etc:  ___Yes   ___No   ___N/A
    Explain: ____________________________________________________________

- Stop breathing episodes or pausing; fluctuation in snoring or breathing
- Sweating at night
- Waking up gasping for air or short of breath
- Waking up coughing
- Waking up with heartburn or a sour taste in the back of my mouth
- Waking up with a dry mouth
- Waking up with a headache

My ability to fall asleep and stay asleep may at times be affected by:

- Pain
- Restless legs
Sleep related symptoms continued

My ability to fall asleep and stay asleep may at times be affected by:
- Indigestion/heartburn
- Hunger
- Need to use the bathroom (nocturia)
- Irritable bowel symptoms
- Worry
- Anxiety
- Sadness
- Work schedule or work related issues
- Family

I have experienced or been told that:
- I sleep talk – without recollection
- I sleep walk – without remembering what I did
- I sleep eat – without remembering - perhaps finding evidence of such the next morning
- I appear to have awakened but am confused - not remembering the apparent awakening the next morning
- I experience night terrors without recollection the next morning
- I make rocking or rolling movements in my sleep and am unaware of my restlessness
- I dream
- My dreams are vivid, disturbing and are like “nightmares”
- I have acted out dreams or am very active during my dreams disturbing my spouse/bed partner which prompts them to wake me up
- I have experienced a seizure during sleep
The Epworth Sleepiness Scale
How Sleepy Are You?

Please score the following situations based on the following number assignments:

- **0** = No Chance of dozing
- **1** = Chance of dozing Slight
- **2** = Chance of dozing Moderate
- **3** = Chance of dozing High

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<th>Situation</th>
<th>PATIENT’S RESPONSE</th>
<th>FAMILY’S RESPONSE</th>
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<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
<td></td>
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<tr>
<td>Sitting inactive in a public place (e.g., a theater or a meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<td></td>
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<tr>
<td>Sitting and talking to someone</td>
<td></td>
<td></td>
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<tr>
<td>Sitting quietly after a lunch <strong>without alcohol</strong></td>
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<td></td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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<td><strong>TOTAL</strong></td>
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Daytime / Wake-time symptoms

Sleepiness:

- I have been involved in a motor vehicle accident due to sleepiness
- I have experienced a “near-miss” while driving due to sleepiness
- I have fallen asleep or closed by eyes while waiting at an intersection
- I have driven a distance and not recalled the details of the drive
- I have experienced a persistence of dream like images while awakening
- I have experienced a feeling of paralysis (inability to move) upon awakening
- I have experienced sudden muscle weakness with excitement

Other Sleep Issues you wish to bring to the physician’s attention:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Physician Signature_________________________Date ___/___/___   Time ___:___