WINDSOR SLEEP CLINIC
Sleep Questionnaire

Date: _____

Last Name: _____First Name: _____
DOB: _____ Age: _____ Sex: Male Female Other _____

Height: _____ Weight: _____ BMI: _____ Neck: _____

Blood Pressure: _____ Heart Rate: _____
Occupation: _____
Referring Physician: _____
Other Physician(s) who should be informed about your sleep assessment:
_____

What are your concerns regarding your sleep?
_____

How long have you had this problem? _____

Sleep Hours:

Bed time? _____ If different on weekends, please indicate: _____
How long does it typically take you to fall asleep (minutes)? _____
Number of awakenings during the night? _____
How many times do you visit the bathroom during the night? _____
Any trouble falling back asleep after awakening(s)? _____
If yes, how long does it take to fall back asleep? _____
Wake time? _____ If different on weekends, please indicate: _____
Do you feel refreshed in the morning? Y N
Preferred sleeping positions (circle all the apply): back side stomach

Naps? Y N **If yes, how many per week? _____ How long are they? _____**

Epworth Sleepiness Scale

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

Situation	**Chance of Dozing/ Sleeping**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
Being a passenger in a motor vehicle for an hour or more	0 1 2 3
Lying down in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (no alcohol)	0 1 2 3
Stopped for a few minutes in traffic while driving	0 1 2 3
Total Score	

Do you work night shifts? Y N
Do you work changing shifts? Y N
Do you travel frequently across time zones? Y N

Do you snore? Y N **(If yes – circle all that apply below)**
If yes, is it slightly louder than breathing, as loud as talking, louder than talking, very loud-can be heard in adjacent rooms?_____
How often do yousnore? _____
Has your snoring bothered other people? Y N
Has anyone noticed you stop breathing during sleep? Y N
How often do you feel tired after your sleep? _____
During waking time, do you feel tired, fatigued or not up to par? Y N
Have you ever nodded off or fallen asleep while driving a vehicle? Y N
If yes, how often? _____
Do you wake up with dry mouth? Y N
Do you wake up with a headache? Y N
Do you drool on your pillow at night? Y N
Do you experience frequent heartburn or reflux during the night? Y N

Past Medical History

Do you have any of the following medical conditions listed below (please circle all that apply):

Diabetes	Heart attacks/ Angina	Seizures
High blood pressure	Asthma	Fibromyalgia
High cholesterol	Emphysema (COPD)	Chronic Fatigue/ Pain
Irregular heart rate	Rhinitis/ Hay Fever	Depression/ Anxiety
Heart failure	Sinusitis	Thyroid

Other diseases (please specify): _____
_____

Past Surgical History (please list previous surgeries, including ENT surgery, tonsils):
_____
_____

Family History (please list significant items):
_____
_____

Any drug allergies? Y N
If yes, please list the name of drug: _____

Medications (Please list or provide photocopy of medication list):
_____
_____
_____

Social History

Do you have insurance coverage? Y N
Any shift work in the last 5 years? Y N

Do you experience any of the following?

Irresistible urge to move legs when laying down at night? Y N
Talking in sleep? Y N
Grinding or clenching of teeth while sleeping? Y N
Sleepwalking? Y N
Nightmares? Y N
Loss of bladder control in sleep? Y N
Tongue biting in sleep? Y N
Awaken soon after going to sleep or in the morning feeling paralyzed? Y N
Are your dreams so real you cannot tell if you are asleep or awake? Y N
While laughing, or suddenly excited, do you suddenly lose muscle control or lose strength in your face, arms and/ or legs? Y N

How many cups do you drink in a day?
Coffee _____
Cola _____
Tea _____
Alcoholic beverages per week _____
Recreational drugs? Y N **If yes, please specify _____**

Do you smoke? Y N **If no, did you smoke in the past?** Y N

For your sleeping problem, have you tried or had (check all that apply):
□ Relaxation training
□ Relaxation tapes
□ Bed restriction
□ Biofeedback
□ Hypnosis
□ Surgery
□ Machines or prosthetic devices to help you breathe better while sleeping
□ Medication
Other _____

Your sleep environment:
Is your bedroom separate (with its own door) from other living areas in the house? Y N
When you enter your bedroom at night, do you usually feel relaxed? Y N
Can your bedroom be made completely dark? Y N
Can your bedroom be made completely quiet? Y N
Do you use a special surface (bed board, orthopedic mattress, waterbed, etc.)? Y N
Do you have a TV, radio, or stereo in your bedroom? Y N
Do you use your bedroom for any activity other than sleep and intimacy? Y N