SLEEP QUESTIONNAIRE

SLEEP RELATED BREATHING / SLEEP APNEA QUESTIONS:

• Do you snore? Yes___ No___
• Are you aware of or have you been told that you stop breathing during sleep or awaken choking or gasping? Yes___ No___
• Do you awaken with a dry mouth? Yes___ No___
• Is your sleep restless and / or non-refreshing? Yes___ No___
• Do you awaken during the night? Yes___ No___
• Do you urinate at night? Yes___ No___
• If so, how many times? _____ Yes___ No___
• Do you awaken with a headache? Yes___ No___
• If so, how often? _____ per week or _____ per month
• Do you awaken from sleep with heart burn or reflux? Yes___ No___
• If so, how often? _____ times / sleep period / week / month
• Are you fatigued or sleepy during the daytime? Yes___ No___
• Do you take naps during normal waking hours? Yes___ No___
• Do you fall asleep at inappropriate times? Yes___ No___
• Do other family members have sleep apnea? Yes___ No___
• What is your height _____ in inches and weight? _____ in pounds

SLEEP RELATED MOVEMENT DISORDERS:

· Do you have an irresistible urge to move your extremities? Yes No

· Is the urge to move associated with unpleasant sensations such as pain, discomfort, numbness, tingling, burning, creepy-crawly, and bugs on the skin or just an urge to move? Yes No

· Does the urge to move or unpleasant sensations begin or worsen during periods of inactivity? Yes No

· Does the urge to move or unpleasant sensations begin or worsen during the evening hours? Yes No

· Does the urge to move or unpleasant sensations lessen during periods of activity? Yes No

· Do other family members have restless limb syndrome? Yes No

INSOMNIA:

• Do you have difficulty falling asleep? Yes___ No___
• Do you have difficulty staying asleep? Yes___ No___

SLEEP SCHEDULE:

• What are your typical hours of work? _____
• What time do you eat dinner? _____
• What time do you get into bed? _____
• Are you sleepy or are you just tired or fatigued when you go to bed? _____
• What is your bed time on work / school days? _____
• What is your rise time on work / school days? _____
• What is your bed time on days off of work / school (usual if retired)? _____
• What is your rise time on days off of work / school (usual if retired)? _____
• If you had no work, school or social obligations, what time would you prefer to go to bed? _____
• If you had no work, school or social obligations, what time would you prefer to awaken? _____

• From the time you turn out the light with the intent of going to sleep, how long does it typically take you to fall asleep?_____
• If you awaken from sleep, what awakens you? _____
• If you awaken from sleep, do you have difficulty falling back asleep? Yes___ No___
• If you "sleep in", do you feel more rested than when you arise at your normal time? _____
• Do you deliberately nap? Yes___ No___
• If so, how often, at what time(s) and for how long? _____
• Do you fall asleep at inappropriate times? Yes___ No___

SLEEP HABITS:

Do you have 30-60 minutes of relaxation or quiet before going to bed? Yes No
Do you do work, use your computer, play video games, talk on the phone, text
or doing other stimulating activities right up until or near bedtime? (Check all that apply) Yes No
Do you read or watch TV in bed? (Check all that apply) Yes No
If you have difficulty falling or staying asleep, o are you anxious about your sleep? Yes No
Do you worry how you will function the next day? Yes No
Do you have a wandering mind? Yes No
Do you tend to watch the clock? Yes No
Do you stay in bed and try harder to fall asleep? Yes No
Do you go into another room? Yes No
Is your bedroom environment dark? Yes No
Is your bedroom environment quiet? Yes No
Is your bedroom environment at a comfortable temperature? Yes No
Is your bed comfortable? Yes No
Do you exercise regularly? Yes No
How often do you exercise? What time do you exercise?
Do you use alcohol, sleeping pills or OTC sleep aids or supplements to help you fall asleep or stay asleep? (Circle all that apply)
Yes No
If yes how often?_____

NARCOLEPSY:

• Are you excessively sleepy during the daytime? Yes___ No___
• Do you have sudden, uncontrollable sleep attacks? Yes___ No___
• Do you fall asleep at inappropriate times or situations (while conversing, while driving or actively doing something? Yes___ No___
• Do you have hallucinations as you fall asleep or awaken from sleep? Yes___ No___
• Do you ever feel paralyzed as you fall asleep or awaken from sleep? Yes___ No___
• Do you experience sudden uncontrollable loss of muscle tone (blurry vision, slurred speech, weakness of an arm or leg or both or collapse to the ground) following strong emotions (laughter, anger, fright, orgasm)? Yes___ No___

THE EPWORTH SLEEPINESS SCALE

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

Chance of Dozing

Sitting and reading.....0 1 2 3
Watching TV..... 0 1 2 3
Sitting, inactive in a public place (eg. a theater or a meeting)..... 0 1 2 3
As a passenger in a car for an hour without a break 0 1 2 3
Lying down to rest in the afternoon when circumstances permit 0 1 2 3
Sitting and talking to someone.....0 1 2 3
Sitting quietly after a lunch without alcohol 0 1 2 3
In a car, while stopped for a few minutes in the traffic.....0 1 2 3

Please add your numbers to get a total score TOTAL SCORE = _____

Fatigue Severity Scale (FSS)

FSS Questionnaire

During the past week, I have found that: Disagree ←----------→ Agree

1. My motivation is lower when I am fatigued. ……1 2 3 4 5 6 7

2. Exercise brings on my fatigue. ……1 2 3 4 5 6 7

3. I am easily fatigued. ……1 2 3 4 5 6 7

4. Fatigue interferes with my physical functioning. ……..1 2 3 4 5 6 7

5. Fatigue causes frequent problems for me. ……1 2 3 4 5 6 7

6. My fatigue prevents sustained physical functioning. ……. 1 2 3 4 5 6 7

7. Fatigue interferes with carrying out certain duties and responsibilities. ..1 2 3 4 5 6 7

8. Fatigue is among my three most disabling symptoms. ……. 1 2 3 4 5 6 7

9. Fatigue interferes with my work, family, or social life. ……. 1 2 3 4 5 6 7

Please add your numbers to get a total score TOTAL SCORE = _____