Sleep Questionnaire

KAISER PERMANENTE®

(Patient label here - office use)

My main sleep problem is: _____

I have seen by a sleep specialist before: ☐ Yes ☐ No
I feel sleepy or fatigued during the day: ☐ Yes ☐ No

If YES:

1. I've had this trouble for _____ years.
2. My sleep problem affects my ability to function at work ☐ Yes ☐ No
3. I take _____ naps a day for _____ minutes per nap.

Stanford Sleepiness Scale	**Degree of Sleepiness**	
This is a quick way to find out how you feel overall. Please read the descriptions to the right and put an X in the box next to the one that best describes how you normally feel during the day.	**1.** Feeling active, vital, alert or wide awake	☐
	2. Functioning at high levels, but not at peak; able to concentrate	☐
	3. Awake, but relaxed; responsive but not fully alert	☐
	4. Somewhat foggy, let down	☐
	5. Foggy; losing interest in remaining awake; slowed down	☐
	6. Sleepy, woozy, fighting sleep; prefer to lie down	☐
	7. No longer fighting sleep, sleep onset soon; having dream-like thoughts	☐
	8. Asleep	☐

Estimated Sleepiness (Epworth Scale)
How likely are you to doze off or fall asleep in the following situations, compared to feeling just tired?
This refers to your usual way of life recently. Even if you haven't done some of these things recently, circle the number that describes how each would have affected you. *(Circle one response for each row)*

Activity or situation	**Would never doze**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car while stopped for a few minutes in traffic	0	1	2	3

Please turn page over to continue

DO NOT SEND FOR SCANNING

On a typical day:

1. I go to bed at _____ (PM | AM).
2. It takes me _____ minutes to fall asleep.
3. I wake up _____ times a night; I go to the bathroom _____ times a night.
4. I wake up at _____ (PM | AM); I actually get out of bed at _____ (AM | PM).
5. I estimate that my total sleep time is _____ hours.
6. I wake up in the morning feeling: ☐ refreshed ☐ unrefreshed

Snoring (as reported by your sleep partner)	*(Circle one response for each row)*			
	Never	**Occasionally**	**Frequently**	**Don't know**
1. My sleep partner tells me that I snore in my sleep	0	1	2	?
2. My sleep partner tells me that I snore loudly and bother others	0	1	2	?
3. My sleep partner tells me that I stop breathing (hold my breath) in my sleep	0	1	2	?
4. I snore so badly I wake myself up	0	1	2	?

Habits:

Caffeine use: _____ cups of caffeinated coffee/day _____ cups of other caffeinated beverages (soda pop, tea)/day
Alcohol use: _____ drinks per day OR _____ drinks per week

Sleep related questions: *(circle one)*

1. I grind my teeth when I'm asleep. ☐ Yes ☐ No ; I wear a night guard device at night. ☐ Yes ☐ No
2. I've had problems with my jaw joint (TMJ [temporomandibular joint] discomfort). ☐ Yes ☐ No
3. Heartburn wakes me up. ☐ Yes ☐ No
4. I have jerky or tingly legs at rest (especially at night). ☐ Yes ☐ No
5. Pain or discomfort makes it hard for me to sleep. ☐ Yes ☐ No
6. When I wake up from sleep, I have a headache ☐ Yes ☐ No OR a dry mouth ☐ Yes ☐ No
7. I have experienced a feeling of being paralyzed when awakening from sleep ☐ Yes ☐ No
8. I act out my dreams ☐ Yes ☐ No; I walk in my sleep ☐ Yes ☐ No
9. When going to sleep or awakening from sleep, I've had hallucinations (hearing or seeing things). ☐ Yes ☐ No

Please list any medicine or substance you take to help you sleep: _____

_____

Driving:

1. Do you drive? ☐ Yes ☐ No
2. Do you have a commercial driver's license? ☐ Yes ☐ No
3. I've had about _____ near misses or accidents caused by drowsiness or sleepiness in the last 5 years.

Other history:

1. I have gained about _____ pounds in the last 5 years.
2. I have a family history of sleep disorders. ☐ Yes ☐ No
3. I have a family history of heart disease. ☐ Yes ☐ No
4. I have a family history of stroke. ☐ Yes ☐ No

Occupation: _____