Vernon Sleep Clinic

R. Cridland M.D. Inc

Sleep Questionnaire

Name: _____ Date: d/m/yr _____

Date of Birth: d/m/yr _____ Age: _____ Marital Status: _____ Sex: M F

Address: _____ City: _____

Province: _____ Postal Code: _____ Health Care #: _____

Home Phone #: _____ Work Phone #: _____

Cell #: _____ E-mail: _____

Occupation: _____ Employer: _____

Referring Physician: _____ Family Physician: _____

Please describe your sleep problems and why you think they may have occurred:

_____

_____

_____

	Work Days	Non-workdays
What time do you go to bed?	_____	_____
How long does it take for you to fall asleep?	_____	_____
Estimate the number of times you wake up during the night?	_____	_____
Average time it takes you to return to sleep?	_____	_____
What time do you finally wake up in the morning?	_____	_____
What time do you actually get up?	_____	_____
Estimate average number of hours of actual sleep, including light sleep?	_____	_____
If you usually use an alarm, what time is it set for?	_____	_____
Do you feel rested when you get up?	_____	_____

How many hours of sleep do you normally need to feel rested? _____

How much caffeine do you use per day? _____

How much nicotine do you use per day? _____ If quit, date quit? _____

How much alcohol do you use per week? _____

Do you use any other recreational drugs? _____

How long have you had trouble with your sleep? _____

Do you have trouble with daytime sleepiness? _____ If yes, for how many weeks/months/years? _____

Do you have trouble with fatigue? _____ If yes, for how many weeks/months/years? _____

Are you aware of anything that triggered your difficulty sleeping? _____

Do you perform shift-work? Yes ☐ No ☐

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Please check all of the following statements that apply to you **on a regular basis:**

□ I have “restless legs” (trouble getting my legs comfortable or keeping them still).
□ I have to stretch my legs or get up and walk around because of the uncomfortable feeling in my legs.
□ I get "creepy-crawly" sensations in my legs when sitting for long periods of time.
□ These sensations in my legs frequently make it hard for me to fall asleep.
□ Chronic pain is a more significant cause of my disturbed sleep than restless legs.
□ I have iron deficiency or anemia.

□ I have trouble sleeping in my bed, but can often sleep in other places.
□ I have a habit of thinking, worrying, planning or problem solving in bed.
□ When in bed, I watch the clock.
□ When lying awake, I feel anxious or frustrated about my inability to sleep.
□ I feel nervous or tense in bed.
□ I look forward to bedtime with anxiety or dread.
□ I am a light sleeper and hear every little noise.

□ I have trouble falling asleep at my usual time, but if I go to bed later when I feel sleepy and then sleep-in, I feel rested.

□ I have panic attacks or episodes of sudden fear. These episodes are associated with:
□ shortness of breath, □ palpitations, □ sweating, □ chest discomfort, □ nausea, □ a choking feeling,
□ hot flashes or chills, □ dizziness, □ numbness or tingling, □ trembling or shaking, □ fear of dying.
□ I worry about having another attack. □ I avoid crowds or being away from home.

□ I usually feel worried, nervous, or fearful.
This is often associated with feelings of: □ restlessness, □ fatigue, □ muscle tension or discomfort,
□ insomnia, □ difficulty concentrating, □ irritability.
□ I have worried about many different things on more than half the days in the past six months.
□ When I worry this way, I find that I can’t stop.

□ I am frequently occupied with obsessive thoughts or preoccupations, or performing compulsive behaviors or rituals.
□ These thoughts or activities significantly bother me or interfere with my life.
□ I become anxious if prevented from performing my compulsive behavior or ritual.
□ I am not successful in controlling these thoughts or actions when I wish to.
□ I have been told that I grind my teeth in my sleep.
□ I wake up with a headache or a sore jaw.

I have been told that in my sleep I: □ talk, □ scream, □ walk.

□ This significantly disrupts the sleep of my bed-partner.

□ I am concerned about harming myself or someone else in my sleep.

I have been told that in my sleep I: □ snore loudly, □ snort, □ gasp, □ choke, □ twitch.

□ I have been told that I stop breathing in my sleep.

I am aware of waking myself: □ snorting, □ gasping, □ choking, □ sweating.

□ I am a restless sleeper.

I often wake up with a: □ headache, □ dry mouth, □ sore throat.

As an adult, I have gained _____ pounds over a period of _____ year(s) time.

As an adult, my collar size has increased in size from _____ to _____.

I have been told that in my sleep I: □ twitch, □ kick, □ jerk.

□ I wake up with the bed all messed up.

□ I have had sciatica, numbness or tingling in my legs.

□ I sometimes wake up hallucinating that something is in the room that really is not there.

□ I sometimes wake up paralyzed, unable to move for a few seconds or minutes.

□ I sometimes get so sleepy during the day that I fall asleep when I don't want to.

□ I sometimes do something (like driving somewhere) and don't remember doing it.

□ In response to a strong emotional event, such as laughing, surprise or anger, I can suddenly become so weak that my knees buckle, my head droops, my jaw drops, I have trouble speaking, or I fall down.

□ Someone in my family has similar problems to those listed in the previous 5 statements.

□ In the past 2 weeks, I have been feeling down, depressed or hopeless nearly every day.

□ I have lost interest or pleasure in things that I used to enjoy.

In addition to checking one of the above two statements, I have:

□ trouble falling asleep or excessive sleeping, □ fatigue, □ poor appetite or overeating,

□ feelings of worthlessness or failure, □ suicidal thoughts, □ trouble concentrating,

□ restlessness, or excessive slowness of speech or movement.

□ I experience a recurrence of depression in the fall, which resolves in the spring.

I experience the following symptoms in the winter, which then resolve in the spring: □ increased fatigue, □ sleeping more, □ increased appetite, □ craving bread and starchy foods, □ weight gain.

□ I think I should cut down on my drinking. □ I feel guilty or upset about my drinking.

□ Someone has complained about my drinking.

□ I have had five or more drinks on a single day in the past month.

□ My doctor suggested that I stop drinking because it was affecting my health.

Please list all hospitalizations, surgeries, childbirths, or injuries requiring treatment:

Year	Reason for hospitalization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list other present or past medical conditions:

Name of illness	Year of onset	Year of diagnosis	Year resolved
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you have seen a psychologist or psychiatrist, or had problems with anxiety or depression, please describe.

_____

_____

Please list all prescription and non-prescription medications including, herbs, vitamins and other supplements taken in the past month:

Name of medication or supplement	Dosage	Date started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other medications you have taken for your sleep in the past: _____

_____

_____

Please list allergies or known adverse reactions to medications or other substances:

_____

_____

Please list any sleep problems, anxiety, depression or other health problems in your biological parents, siblings and children:

Mother _____ Father _____

Siblings _____

Children _____

Please answer the following:

Birthplace _____ # of siblings _____

Formal education level _____

Spouse's occupation _____ Number of children_____

Have you been on disability? Yes No

If yes, when? _____

Why? _____

Are you currently involved in litigation? Yes No

Please check which symptoms you have experienced in the past six months. Check (√) "O" for occasionally or "F" for frequently experienced. Do **not** check if not applicable.

O	F		O	F	
□	□	visual problems	□	□	neck, back or joint pain
□	□	hearing problems	□	□	muscle or tissue pain
□	□	nasal congestion	□	□	fever, chills or night sweats
□	□	cough	□	□	heat or cold intolerance
□	□	shortness of breath	□	□	weakness
□	□	chest pains	□	□	dizziness
□	□	irregular heart beat	□	□	fainting, falling or seizures
□	□	ankle swelling	□	□	problems at home or in family
□	□	indigestion or heart burn	□	□	problems at work
□	□	constipation or diarrhea	□	□	(women) pre-menstrual problems
□	□	sexual difficulties			Are you in menopause? Y N
□	□	headaches	□	□	menopausal symptoms

What forms of exercise do you do? _____

How many times a week do you exercise and for how long? _____

Height: _____ Weight: _____ Amount of weight □ gained / □ lost in the past year? _____

The Epworth Sleepiness Scale

Please use this scale to rate the likelihood of you DOZING or FALLING 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 estimate how they would have affected you:

	Never	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g.: theatre or 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 traffic	0	1	2	3

Bed Partner / Family Member / Roommate Questionnaire

The following portion of the questionnaire is to be completed by the patient's bed partner, family member or roommate noting their observations when the patient is sleeping.

Name of patient: _____ Date: _____

Your relationship to patient: _____ Your Name: _____

Check any of the behaviors that you have observed in the patient while he/she is asleep:

	Year 1st noticed (if present)
☐ restless sleep	_____
☐ soft snoring	_____
☐ loud snoring	_____
☐ snoring in positions other than on back	_____
☐ pauses in breathing: Are the pauses repetitive? Yes No	_____
☐ pauses in breathing in positions other than on back	_____
☐ snorting	_____
☐ gasping for air	_____
☐ choking	_____
☐ repeated leg, arm or body twitching	_____
☐ grinding teeth	_____
☐ sleep talking	_____
☐ sleep walking	_____
☐ rocking or head banging	_____
☐ sitting up in bed but not awake	_____
☐ episodes of becoming very rigid, shaking or seizure	_____

Please describe the behaviors checked above in more detail. Include a description of the activity, the time of night when it occurs, its frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

Please include any other useful information for the doctor, or concerns you may have, not previously addressed. Thank you.

_____

_____

_____