

# Central Florida Pulmonary Group, P.A.

## Sleep Questionnaire

Account
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Patient's Name	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight	Height	Today's Date
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### Part 1

**Instructions:** Please circle that one number following each statement that best describes how often you have had any of these experiences. Unless otherwise noted, the statements refer to what has been happening to you during the past six (6) months. Circling number "1" after a statement means that you have never had that experience, whereas circling number "5" means that you almost always have that experience.

<b>Answer Key:</b> 1 = Never    2 = Rarely    3 = Sometimes    4 = Usually    5 = Always
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1. I have difficulty falling asleep \_\_\_\_\_ 1 2 3 4 5
2. When I awaken during the night I am unable to fall back to sleep \_\_\_\_\_ 1 2 3 4 5
3. At bedtime I am afraid of not being able to fall asleep \_\_\_\_\_ 1 2 3 4 5
4. I sleep better when sleeping away from my home \_\_\_\_\_ 1 2 3 4 5
5. Thoughts race through my mind when I am trying to go to sleep \_\_\_\_\_ 1 2 3 4 5
6. I use alcohol to help me get to sleep \_\_\_\_\_ 1 2 3 4 5
7. I use medications to help me get to sleep \_\_\_\_\_ 1 2 3 4 5
8. My sleep is disturbed because of pain \_\_\_\_\_ 1 2 3 4 5
9. I am anxious or depressed \_\_\_\_\_ 1 2 3 4 5
10. I have been told that I snore \_\_\_\_\_ 1 2 3 4 5
11. I have been told that my snoring can be heard in other rooms of the house \_\_\_\_\_ 1 2 3 4 5
12. I suddenly wake up gasping or choking \_\_\_\_\_ 1 2 3 4 5
13. I have been told I stop breathing at times during my sleep \_\_\_\_\_ 1 2 3 4 5
14. I have headaches when I wake up in the morning \_\_\_\_\_ 1 2 3 4 5
15. At times during the day I struggle to stay awake \_\_\_\_\_ 1 2 3 4 5
16. I have trouble at work or school because of sleepiness \_\_\_\_\_ 1 2 3 4 5
17. I have fallen asleep during the day involuntarily \_\_\_\_\_ 1 2 3 4 5
18. At times during the day I am so tired that I find myself doing things that make no sense \_\_\_\_\_ 1 2 3 4 5
19. I have been told that I kick my legs when I sleep \_\_\_\_\_ 1 2 3 4 5
20. My sleep is disturbed by aching or crawling sensations in my legs \_\_\_\_\_ 1 2 3 4 5
21. I get out of bed to walk and stretch my legs because of discomfort \_\_\_\_\_ 1 2 3 4 5
22. When awakening or falling asleep, I have been awake but felt paralyzed or unable to move \_\_\_\_\_ 1 2 3 4 5
23. When awakening or falling asleep, I have experienced vivid dreamlike visions or heard voices \_\_\_\_\_ 1 2 3 4 5
24. I have sudden attacks of muscular weakness when laughing, crying or otherwise very emotional \_\_\_\_\_ 1 2 3 4 5
25. I sleep walk at times \_\_\_\_\_ 1 2 3 4 5
26. I wake up screaming, confused or violent at times \_\_\_\_\_ 1 2 3 4 5

Please continue on the next page.

**Part 2 – 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:

**Answer Key: 0 = Would never doze 1 = slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing**

- |   |   |   |   |   |
|---|---|---|---|---|
| 1. Sitting and reading _____  | 0 | 1 | 2 | 3 |
| 2. Watching T.V. _____  | 0 | 1 | 2 | 3 |
| 3. Sitting inactive in a public place (i.e. a theatre, a 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 when circumstances permit _____  | 0 | 1 | 2 | 3 |
| 6. Sitting and talking to someone _____                                 | 0 | 1 | 2 | 3 |
| 7. Sitting quietly after a lunch without alcohol _____                  | 0 | 1 | 2 | 3 |
| 8. In a car, while stopped for a few minutes in traffic _____           | 0 | 1 | 2 | 3 |

**Part 2**

1. Do you work shifts or irregular hours? If so, please explain:
2. Is there a history for sleep problems in your family? If so, please explain:
3. Do you seem to sleep best at times different from most people you know? If so, please explain:
4. Did you have sleeping problems during childhood (i.e. sleep walking, night terrors, etc)? If so, please explain:
5. Do you drink caffeinated beverages (i.e. coffee, tea, colas)? If so, how many drinks per day?
6. Have you had any history for emotional or other psychiatric problems? If so, please explain:
7. Are there any other issues that you would like to bring to the doctors attention? If so, please explain: