CFPG Sleep Questionnaire

Office Use Only		
Account	Date	☐Hospital ☐Mills ☐East ☐North

Please Print

Patient Information

Patient Name: _____ **Today's Date:** _____

Sex: ❒**Male** ❒**Female** **Weight:** _____**lbs.** **Height:** _____**foot** _____**inches** **Age:** _____

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.

Answer Key: 1 = Never 2 = Rarely 3 = Sometimes 4 = Usually 5 = Always

1.	I have difficulty falling asleep _____	1	2	3	4	5	1
2.	When I awaken during the night I am unable to fall back to sleep _____	1	2	3	4	5	1
3.	At bedtime I am afraid of not being able to fall asleep _____	1	2	3	4	5	1
4.	I sleep better when sleeping away from my home _____	1	2	3	4	5	1
5.	Thoughts race through my mind when I am trying to go to sleep _____	1	2	3	4	5	1
6.	I use alcohol to help me get to sleep _____	1	2	3	4	5	1
7.	I use medications to help me get to sleep _____	1	2	3	4	5	1
8.	My sleep is disturbed because of pain _____	1	2	3	4	5	1
9.	I am anxious or depressed _____	1	2	3	4	5	1
10.	I have been told that I snore _____	1	2	3	4	5	1
11.	I have been told that my snoring can be heard in other rooms of the house _____	1	2	3	4	5	1
12.	I suddenly wake up gasping or choking _____	1	2	3	4	5	1
13.	I have been told I stop breathing at times during my sleep _____	1	2	3	4	5	1
14.	I have headaches when I wake up in the morning _____	1	2	3	4	5	1
15.	At times during the day I struggle to stay awake _____	1	2	3	4	5	1
16.	I have trouble at work or school because of sleepiness _____	1	2	3	4	5	1
17.	I have fallen asleep during the day involuntarily _____	1	2	3	4	5	1
18.	At times during the day I am so tried that I find myself doing things that make no sense ____	1	2	3	4	5	1
19.	I have been told that I kick my legs when I sleep _____	1	2	3	4	5	1
20.	My sleep is disturbed by aching or crawling sensations in my legs _____	1	2	3	4	5	1
21.	I get out of bed to walk and stretch my legs because of discomfort _____	1	2	3	4	5	1
22.	When awakening or falling asleep, I have been awake but felt paralyzed or unable to move ___	1	2	3	4	5	1
23.	When awakening or falling asleep, I have experienced vivid dreamlike visions or heard voices ___	1	2	3	4	5	1
24.	I have sudden attacks of muscular weakness when laughing, crying or otherwise very emotional ___	1	2	3	4	5	1
25.	I sleep walk at times _____	1	2	3	4	5	1
26.	I wake up screaming, confused or violent at times _____	1	2	3	4	5	1

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Part 2 – The Epworth Sleepiness Scale

How likely are you to dose 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	0
2.	Watching T.V. _____	0	1	2	3	0
3.	Sitting inactive in a public place (i.e. a theatre, a meeting _____	0	1	2	3	0
4.	As a passenger in a car for an hour without a break _____	0	1	2	3	0
5.	Lying down to rest in the afternoon when circumstances permit _____	0	1	2	3	0
6.	Sitting and talking to someone _____	0	1	2	3	0
7.	Sitting quietly after a lunch without alcohol _____	0	1	2	3	0
8.	In a car, while stopped for a few minutes in traffic _____	0	1	2	3	0

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: