Northern Virginia ENT
ALLERGY·SLEEP·HEARING

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SLEEP QUESTIONNAIRE

NAME_____ DOB_____

History Questionnaire Ht _____ Wt _____ Neck Size _____

EPWORTH SLEEP SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate 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

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g., school or movie)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in traffic	
Total (Range 0-24):	

1. What is your primary sleep problem?

_____

_____

_____

_____

2. How long have you had that problem?

_____

3. What time do you usually go to bed and get up?

Weekdays	go to bed	AM	PM
	get up	AM	PM
Weekends	go to bed	AM	PM
	get up	AM	PM

4. How many nights a week do you get:

9+ hours of sleep?	nights
8 hours of sleep?	nights
7 hours of sleep?	nights
6 hours of sleep?	nights
5 or less hours of sleep?	nights

5. How often do you nap? _____/wk For how long? _____/min
6. Do you wake up feeling unrefreshed? ❒ Yes ❒ No
7. Do you have trouble during the day because you are not getting enough sleep? ❒ Yes ❒ No

SLEEP APNEA

8. Do others complain about your snoring? ❒ Yes ❒ No
9. Has anyone witnessed you during an apneic event? (Have you been told that you stop breathing during sleep, or is there a silent period when there is no longer snoring followed by a loud snort or a body jerk?) ❒ Yes ❒No If so, how often?_____nights/wk
10. Do you awaken from sleep short of breath or with a feeling of being choked? ❒ Yes ❒ No
11. Do you have morning headaches? ❒ Yes ❒ No
12. Weight gain or loss over the past 12 months? ❒ Yes ❒ No
13. Do you have high blood pressure? ❒ Yes ❒ No
    If so, are you currently on medication? ❒ Yes ❒ No
14. Have you ever used Continuous Positive Airway Pressure therapy or CPAP? ❒ Yes ❒ No
    If so, what year was your CPAP first prescribed? _____
    How often do you use your CPAP now? _____
    Please describe any problem you have or had with CPAP:

    _____

    _____

    _____

15. Have you ever used a dental appliance for sleep apnea? ❒ Yes ❒ No
    If so, what year was your dental appliance first prescribed? _____

How often do you use your dental appliance now? _____

Please describe any problem you have or had with your dental appliance:

_____

16. Have you ever had surgery for sleep apnea? ❒ Yes ❒ No

If so, what year was your surgery? _____

NARCOLEPSY

17. Do you feel your knees buckle, arms feel weak, or jaw drop with strong ❒ Yes ❒ No emotions (startled, angry, happy, or sad)?
18. Do you experience vivid dream-like episodes or scenes upon ❒ Yes ❒ No awakening or falling asleep that you can't tell whether they are real or not? (hypnagogic hallucinations)
19. Do you feel paralyzed when waking or falling asleep? ❒ Yes ❒ No
20. Do you fall asleep at inappropriate times or experience sleep attacks? ❒ Yes ❒ No

MOVEMENTS DURING SLEEP

21. Do you wake yourself with body jerks (arms or legs)? ❒ Yes ❒ No
22. Have you been told that your legs or arms move every 20 seconds ❒ Yes ❒ No or so during the night?
23. Do you have any uncomfortable sensations (e.g. insects crawling) in your legs ❒ Yes ❒ No that make it difficult for you to sleep?
24. Do you feel the urge to move or constantly reposition your legs while sitting or ❒ Yes ❒ No lying still?

PARASOMNIAS

25. Do you have night terrors? ❒ Yes ❒ No
26. Do you often move violently during your sleep while dreaming, ❒ Yes ❒ No and sometimes even hurt yourself or your partner by accident or fall out of bed?
27. Have you hurt yourself or anyone else associated with these ❒ Yes ❒ No movements during the night?
28. Have you been told that you sleepwalk? ❒ Yes ❒ No
29. Have you been told that you arouse from sleep totally confused ❒ Yes ❒ No or are inconsolable?
30. Do you have a history of seizures? ❒ Yes ❒ No

INSOMNIA

31. Check if you are currently diagnosed with: ❒ Depression ❒ Anxiety
32. Do you routinely require more than 30 minutes to fall asleep? ❒ Yes ❒ No
33. Do you wake up several times during the night and cannot get back to sleep? ❒ Yes ❒ No
    What causes you to wake up?_____
34. Do you often wake up one or two hours before your scheduled wake time and ❒ Yes ❒ No get back to sleep?
35. Do you have thoughts racing through your mind while trying to fall asleep? ❒ Yes ❒ No
36. Do you watch a clock while trying to sleep? ❒ Yes ❒ No

37. Do you read or watch TV in bed? ❒ Yes ❒ No

BRUXISM

38. Do you have morning jaw pain? ❒ Yes ❒ No
39. Do you grind your teeth during sleep? ❒ Yes ❒ No

SOCIAL HISTORY

40. Caffeine consumption: ❒ Regular ❒ Occasional ❒ None Quantity: _____
    When do you typically consume your last serving of caffeine? _____AM/PM
41. Alcohol use: ❒ Regular ❒ Occasional ❒ None Quantity: _____
    Drink Type: _____ ; _____ per night
    How many hours before bed? _____
42. Smoking habits:
    How many per day? _____ Over how many years? _____

FAMILY HISTORY

Snoring ❒ Father ❒ Mother ❒ Siblings
Sleep Apnea ❒ Father ❒ Mother ❒ Siblings
Insomnia ❒ Father ❒ Mother ❒ Siblings
Narcolepsy ❒ Father ❒ Mother ❒ Siblings

MISCELLANEOUS

43. Are you a shift worker? ❒ Yes ❒ No
    If you answered "Yes," please list down the hours:
    _____