Northwestern Medicine®

Appointment Date & Time: _____ /_____

Location: CDH DELNOR

Physician: _____

Initial Sleep Questionnaire

Name: _____ **Date of Birth:** _____

My main sleep complaint is (please explain):

What is Your Sleep Schedule?

1. What is your normal bedtime on Weekdays? Weekends? _____ /_____
2. What is your rise time on Weekdays? Weekends? _____ /_____
3. Amount of time it takes to fall asleep Weekdays? Weekends? (hrs./min.) _____ /_____
4. Average number of awakenings per night Weekdays? Weekends? _____ /_____
5. Number of naps per day Weekdays? Weekends? _____ /_____
6. How many hours do you think you sleep during the night? _____

What is Your Epworth Sleepiness Score?

What is your chance of falling asleep or dozing in the following situations?

Chance of Dozing

0= would never doze **1= slight change of dozing** **2= moderate chance of dozing** **3= high chance of dozing**

SITUATION:	CIRCLE ONE:			
1. Sitting and Reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place	0	1	2	3
4. As a passenger in a car for an hour	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 a lunch, without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3
(A score of 10 or higher may indicate excessive daytime sleepiness)	TOTAL:			

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

***FLIP OVER AND COMPLETE OTHER SIDE* ⇨

The following table contains symptoms, risk factors, behaviors and other items associated with sleep problems. Please check all that apply, even if something occurs only once in a while. If you have a bed partner or there is someone who has observed your sleep, ask that person to help you complete this form.

SLEEP APNEA	✓
Loud snoring	
Waking up gasping, choking, or coughing	
Stop breathing in sleep	
Wake up with dry mouth	
Overweight	
Large neck size (males > 17 in, females > 16 in.)	
Acid reflux at night	
Have to urinate at least twice per night	
Nasal congestion or allergies	
High blood pressure	
Coronary artery disease	
Atrial fibrillation	
Heart failure	
History of stroke	
Diabetes mellitus	
Postmenopausal	
Age 65 or older	
Had a previous sleep study?	
Have used a CPAP or oral appliance for sleep apnea?	
Drink alcohol or take sedating medicines near bedtime?	
Frequently wake with a headache	

INSOMNIA	✓
Difficulty falling asleep	
Difficulty staying asleep	
Waking too early	
Non-refreshing sleep	
Restless sleep	
Not getting enough sleep	
Irregular sleep schedule	
Mind racing	
Travel (time zones)	
Pain or discomfort	
Depression	
Anxiety	
Job Stress	
Relationship problems	
Shift work	

DAYTIME PROBLEMS	✓
Sleepiness	
Fatigue	
Irritable/moody	
Difficulty concentrating	
Inattentiveness	
Memory problems	
Dozing off unintentionally	
Napping on purpose	
Sleepy while driving	
Accidents due to sleepiness	
Dozing off at work or school	

PARASOMNIAS	✓
Sleep walking	
Sleep talking	
Sleep eating	
Sleep terrors or nightmares	
Whole body jerks just before falling asleep	
Acting out dreams	
Teeth grinding	

RESTLESS LEGS	✓
Urge to move legs when trying to sleep	
Tingling or crawling feeling in the legs	
Urge to move is worse when seated or lying	
Moving legs helps to relieve discomfort	
Symptoms worse in the evening or at bedtime	
Muscle cramps during sleep	

NARCOLEPSY	✓
Muscle weakness with strong emotion	
Dream-like hallucinations when falling asleep or waking up	
Feeling paralyzed when falling asleep or waking up	