Patient name: _________________________________________________ Date: _________________

In order for us to better understand your sleep problem, please answer the following questions to the best of your ability. If available, please ask your bed partner or observer for input.

Presenting problem:
Please briefly describe your sleep problem.

How long have you had this problem?

Has it changed in recent years?  □ Yes  □ No  If so, how?

Who referred you to us? _____________________________________________________

Previous sleep study
Have you ever had a sleep study (polysomnogram)?
  □ No, please skip to the next question.
  □ Yes, Institution or sleep laboratory name: __________________________________________
  Date: _________________ Results: __________________________________________
  Please arrange for a copy to be sent to us, if possible.

Previous treatment
Please list any previous treatment, whether prescribed or performed by a physician, or just tried on your own.

Sleep history
Average sleep schedule during the week:
  Go to bed at what time? _______ a.m. p.m. _______ a.m. p.m.
  Get up at what time? _______ a.m. p.m. _______ a.m. p.m.

Does your bedtime and/or waking time vary much? □ yes □ no
  If so, how much? __________________

Average time it takes you to fall asleep: _______ min _______ min
Average amount of time you sleep each night: _______ hr. _______ hr.
Average number of times you awaken at night: _______ times _______ times
How do you awaken?
  _______ spontaneously
  _______ alarm clock
  _______ other

Do you use a snooze alarm? □ yes □ no

Do you return to bed after arising? □ yes □ no

Do you take naps? □ yes □ no
  If yes, how many times per day? _______ times _______ times
The following is a list of symptoms that may be experienced by people with sleep disorders. Please mark all those symptoms that you have experienced.

- Complaints from others about your snoring
- Bed partner sleeps in another room because of your snoring
- Loud snoring when sleeping on your back
- Loud snoring when sleeping on your side
- Loud snoring even when sitting up
- Stop breathing during sleep
- Choke or gasp during sleep
- Awaken with a choking or gasping sensation
- Awaken with heart beating faster than usual
- Awaken feeling frightened
- Awaken frequently during the night
- Unusual movements while asleep
- Sweating during the night
- Difficult nasal breathing during the night
- Dry mouth upon awakening
- Headaches upon awakening
- Awaken feeling tired and unrefreshed
- Feel exhausted despite sleeping many hours
- Unable to get good quality sleep
- Fight sleepiness during daily activities
- Difficulty staying alert when required to
- Fall asleep at the wrong times
- Decreased concentration
- Forgetfulness
- Difficulty getting to sleep
- Often takes more than 30 minutes to fall asleep
- Wake up at night and can’t get back to sleep
- Wake up early and can’t get back to sleep
- Need to use sleep aids
- Unable to sleep at all
- Get only 3-4 hours of sleep on most nights
- Difficulty sleeping away from home
- “Creeping crawling” sensation of legs before sleep
- Leg twitches during sleep
- Wake up feeling paralyzed and unable to move
- Sudden body weakness brought by strong emotions
- Sudden buckling of the knees brought by strong emotions
- Seeing things when trying to sleep
- Hearing voices or noises when going to sleep
- Talking while asleep
- Walking while asleep
- Eating during the night
- Grinding teeth while asleep
- Often recall your dreams
- Disturbing dreams
Center for Ear, Nose, Throat & Allergy, P.C.
Sleep/Wake Questionnaire

Patient name: _________________________________________________ Date: ______________________

Daytime sleepiness
The following questions relate to your level of tiredness. How likely are you to doze off or fall asleep in these situations? Use the following scale to choose the most appropriate answer for each situation:

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

<table>
<thead>
<tr>
<th>Chance of dozing</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sitting and reading</td>
</tr>
<tr>
<td></td>
<td>Watching TV</td>
</tr>
<tr>
<td></td>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
</tr>
<tr>
<td></td>
<td>As a passenger in a car for an hour without a break</td>
</tr>
<tr>
<td></td>
<td>Lying down to rest in the afternoon when circumstances permit</td>
</tr>
<tr>
<td></td>
<td>Sitting and talking to someone</td>
</tr>
<tr>
<td></td>
<td>Sitting quietly after a lunch without alcohol</td>
</tr>
<tr>
<td></td>
<td>In a car, while stopped for a few minutes in the traffic</td>
</tr>
</tbody>
</table>

Total

Are you bothered by sleepiness under other circumstances?  
Yes   No
If Yes, describe:__________________________________________________________________________
_______________________________________________________________________________________

Have you been in a car accident due to falling asleep at the wheel?  
Yes   No   Near miss
If Yes, describe:_______________________________________________________________________
_______________________________________________________________________________________

Have you had other types of accidents because of sleepiness?  
Yes   No
If Yes, describe:_______________________________________________________________________
_______________________________________________________________________________________

Reviewed by ___________________________________________ Date ______________________
Physician