CENTER FOR EAR, NOSE, THROAT & ALLERGY, P.C.
Sleep/Wake Questionnaire

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

	Work days	**Weekends**
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	☐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	____ spontaneously
	____ alarm clock	____ alarm clock
	____ other	____ other
Do you use a snooze alarm?	☐yes ☐no	☐yes ☐no
Do you return to bed after arising?	☐yes ☐no	☐yes ☐no
Do you take naps?	☐yes ☐no	☐yes ☐no
If yes, how many times per day?	_____ times	_____ times

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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

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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

Chance of dozing	**Situation**
_____	Sitting and reading
_____	Watching TV
_____	Sitting inactive in a public place (e.g. a theater or a meeting)
_____	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 without alcohol
_____	In a car, while stopped for a few minutes in the traffic

_____ **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