TheSleepClinics.ca

Dr. Ronald Cridland Inc

Sleep Questionnaire

Name: ____ Date: d/m/yr ____________________

Date of Birth: d/m/yr _________________________ Age: _________ Marital Status: ______________

Sex: M F Other:_____________________________

Address: ____ City: ___________________

Province: ______________________ Postal Code: ____________ Health Care #: __________________

Home Phone #: ____________________________ Work Phone #: ______________________________

Occupation: _______________________________ Employer: _________________________________

Referring Physician: _________________________ Family Physician: ___________________________

Please describe your sleep problems and why you think they may have occurred:

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	Work Days	Non-workdays
What time do you go to bed?	__________	__________
How long does it take for you to fall asleep?	__________	__________
Estimate the number of times you wake up during the night?	__________	__________
Average time it takes you to return to sleep?	__________	__________
What time do you finally wake up in the morning?	__________	__________
What time do you actually get up?	__________	__________
Estimate average number of hours of actual sleep, including light sleep?	__________	__________
If you usually use an alarm, what time is it set for?	__________	__________
Do you feel rested when you get up?	__________	__________

How many hours of sleep do you normally need to feel rested? __________

How much caffeine do you use per day? ____________________________________

How much nicotine do you use per day? ______________________ If quit, date quit? ______________

How much alcohol do you use per week? ____________________________________

Do you use any other recreational drugs? ____________________________________

How long have you had trouble with your sleep? ____

Do you have trouble with daytime sleepiness? _____ If yes, for how many weeks/months/years? _________

Do you have trouble with fatigue? ______ If yes, for how many weeks/months/years? ________________

Are you aware of anything that triggered your difficulty sleeping? ___________________________________

Do you perform shift-work? Yes No

Please check all of the following statements that apply to you **on a regular basis:**

I have "restless legs" (trouble getting my legs comfortable or keeping them still).
I have to stretch my legs or get up and walk around because of the uncomfortable feeling in my legs.
I get "creepy-crawly" sensations in my legs when sitting for long periods of time.
These sensations in my legs frequently make it hard for me to fall asleep.
Chronic pain is a more significant cause of my disturbed sleep than restless legs.
I have iron deficiency or anemia.

I have trouble sleeping in my bed, but can often sleep in other places.
I have a habit of thinking, worrying, planning or problem solving in bed.
When in bed, I watch the clock.
When lying awake, I feel anxious or frustrated about my inability to sleep.
I feel nervous or tense in bed.
I look forward to bedtime with anxiety or dread.
I am a light sleeper and hear every little noise.

I have trouble falling asleep at my usual time, but if I go to bed later when I feel sleepy and then sleep-in, I feel rested.

I have panic attacks or episodes of sudden fear. These episodes are associated with:
shortness of breath palpitations sweating chest discomfort nausea a choking feeling
hot flashes or chills dizziness numbness or tingling trembling or shaking fear of dying
I worry about having another attack. I avoid crowds or being away from home.

I usually feel worried, nervous, or fearful.
This is often associated with feelings of: restlessness fatigue muscle tension or discomfort
Insomnia difficulty concentrating irritability
I have worried about many different things on more than half the days in the past six months.
When I worry this way, I find that I can't stop.

I am frequently occupied with obsessive thoughts or preoccupations, or performing compulsive behaviors or rituals.
These thoughts or activities significantly bother me or interfere with my life.
I become anxious if prevented from performing my compulsive behavior or ritual.
I am not successful in controlling these thoughts or actions when I wish to.
I have been told that I grind my teeth in my sleep.
I wake up with a headache or a sore jaw.
I have been told that in my sleep I: talk scream walk

This significantly disrupts the sleep of my bed-partner.

I am concerned about harming myself or someone else in my sleep.

I have been told that in my sleep I: snore loudly snort gasp choke twitch.

I have been told that I stop breathing in my sleep.

I am aware of waking myself: snorting, gasping, choking, sweating.

I am a restless sleeper.

I often wake up with a: headache dry mouth sore throat

As an adult, I have gained __________ pounds over a period of __________ year(s) time.

As an adult, my collar size has increased in size from _______ to _______.

I have been told that in my sleep I: twitch kick jerk.

I wake up with the bed all messed up.

I have had sciatica, numbness or tingling in my legs.

I sometimes wake up hallucinating that something is in the room that really is not there.

I sometimes wake up paralyzed, unable to move for a few seconds or minutes.

I sometimes get so sleepy during the day that I fall asleep when I don't want to.

I sometimes do something (like driving somewhere) and don't remember doing it.

In response to a strong emotional event, such as laughing, surprise or anger, I can suddenly become so weak that my knees buckle, my head droops, my jaw drops, I have trouble speaking, or I fall down.

Someone in my family has similar problems to those listed in the previous 5 statements.

In the past 2 weeks, I have been feeling down, depressed or hopeless nearly every day.

I have lost interest or pleasure in things that I used to enjoy.

In addition to checking one of the above two statements, I have:

trouble falling asleep or excessive sleeping fatigue poor appetite or overeating

feelings of worthlessness or failure suicidal thoughts trouble concentrating

restlessness excessive slowness of speech or movement.

I experience a recurrence of depression in the fall, which resolves in the spring.

I experience the following symptoms in the winter, which then resolve in the spring:

increased fatigue sleeping more increased appetite craving bread and starchy foods weight gain.

I think I should cut down on my drinking. I feel guilty or upset about my drinking.

Someone has complained about my drinking.

I have had five or more drinks on a single day in the past month.

My doctor suggested that I stop drinking because it was affecting my health.

Please list all hospitalizations, surgeries, childbirths, or injuries requiring treatment:

Year	Reason for hospitalization

Please list other present or past medical conditions:

Name of illness	Year of onset	Year of diagnosis	Year resolved

If you have seen a psychologist or psychiatrist, or had problems with anxiety or depression, please describe.

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Please list all prescription and non-prescription medications including, herbs, vitamins and other supplements taken in the past month:

Name of medication or supplement	Dosage	Date started

Please list other medications you have taken for your sleep in the past:

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Please list allergies or known adverse reactions to medications or other substances:

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Please list any sleep problems, anxiety, depression or other health problems in your biological parents, siblings and children:

Mother ____ Father ______________________________________

Siblings ____

Children ____

Please answer the following:

Birthplace ____ # of siblings ________

Formal education level ____

Spouse's occupation ____ Number of children_________

Have you been on disability? Yes No

If yes, when? ____

Why? ____

Are you currently involved in litigation? Yes No

If you currently require any specific items or the presence of a therapy animal, service animal, or emotional support animal in order to sleep every night, please describe.

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What forms of exercise do you do? ____

How many times a week do you exercise and for how long? ____

Height: ______ Weight: ______ Amount of weight gained lost in the past year? __________________

The Epworth Sleepiness Scale

Please use this scale to rate the likelihood of you DOZING or FALLING ASLEEP in the following situations, in contrast to just feeling 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 estimate how they would have affected you:

	Never	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g.: theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Bed Partner / Roommate Questionnaire

The following portion of the questionnaire is to be completed by the patient's bed partner or roommate noting their observations when the patient is sleeping.

Name of patient: ____ Date: ________________

Your relationship to patient: ____

Check any of the behaviors that you have observed in the patient while he/she is asleep:

Behavior		Year 1st noticed (if present)
restless sleep		__________
soft snoring		__________
loud snoring		__________
snoring in positions other than on back		__________
pauses in breathing: Are the pauses repetitive? Yes	No	__________
pauses in breathing in positions other than on back		__________
snorting		__________
gasping for air		__________
choking		__________
repeated leg, arm or body twitching		__________
grinding teeth		__________
sleep talking		__________
sleep walking		__________
rocking or head banging		__________
sitting up in bed but not awake		__________
episodes of becoming very rigid, shaking or seizure		__________

Please describe the behaviors checked above in more detail. Include a description of the activity, the time of night when it occurs, its frequency during the night, and whether it occurs every night.

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Please include any other useful information for the doctor, or concerns you may have, not previously addressed. Thank you.

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