LITTLETON REGIONAL HEALTHCARE

North Country Sleep Center
580 St. Johnsbury Road, Suite C
Littleton, NH 03561
Ph: (603)259-7780 Fax (603) 259-7778

Adult Sleep Questionnaire

Today's Date: ___/___/____

Demographic Information

Name:_____ Date of Birth: _____
Occupation: _____ Employer:_____
Primary Care Provider:_____

Sleep Problems

1. Please describe in detail the problem(s) that you are having with your sleep, or reason(s) for this appointment:_____
   _____
   _____
2. In your Opinion, what is the **Main Problem** with your sleep:_____
3. How long have you had the above symptoms? _____
4. Have you ever been evaluated and/or treated for a sleep disorder before? ☐Yes ☐No
   If yes, by whom? _____
5. Did you have a sleep study at that time? ☐Yes ☐No
   If yes, are you currently using CPAP/BIPAP/ASV/ORAL APPLIANCE? ☐Yes If yes, which type:_____ ☐No

Sleep Schedule

1. If employed, what are your normal working hours? Start_____am/pm Stop_____am/pm
   If shift work, please list schedule:_____
2. Schedule on ***weekdays***: Usual Bedtime: _____ Usual Wake Time: _____
   Total estimated amount of sleep on weekdays (including naps): _____
3. Schedule on ***weekends***: Usual Bedtime: _____Usual Wake Time: _____
   Total estimated amount of sleep on weekend days (including naps): _____
4. ***Naps:*** Number of days each week that you nap: _____
   Usual nap time: _____ Usual length of naps: _____ Are naps refreshing? ☐Yes ☐No

Sleep Quality

1. Do you sleep: ☐Alone ☐With a bed partner
2. Do you sleep in: ☐Bed ☐Recliner ☐Other:_____
3. Do you have difficulty getting to sleep at night? ☐Yes ☐No
   How long does it usually take you to fall asleep? _____
   Do you take any medication to help with sleep? ☐Yes ☐No If so, what? _____
4. Once asleep, do you wake up during the night? ☐Yes ☐No
   If yes, do you know what wakes you up? _____
   Do you have difficulty going back to sleep? _____
6. What do you do when you are unable to sleep? _____
   _____

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Sleep related symptoms

1. During sleep, do you experience or have been told that you experience:

	No	Occasionally	Frequently
Snoring	☐	☐	☐
Pauses in breathing	☐	☐	☐
Waking up gasping for breath	☐	☐	☐
Coughing spells	☐	☐	☐
Waking up with heartburn	☐	☐	☐
Night sweats	☐	☐	☐
Nasal congestion	☐	☐	☐
Leg kicks or jerks	☐	☐	☐
Grinding your teeth	☐	☐	☐
Waking up with panic attacks	☐	☐	☐
Disturbing nightmares	☐	☐	☐
Pain which affects your sleep	☐	☐	☐
Getting up to urinate	☐	☐	☐
Acting out dreams	☐	☐	☐
Sleep walking or other unusual behaviors	☐	☐	☐

2. Do you experience discomfort or a restless sensation causing a strong urge to move your legs while sitting or lying down? ☐Yes ☐No If yes, does it interfere with sleep? ☐Yes ☐No
3. How often does this sensation occur? _____
4. For each of the following beverages listed below, write the average amount you drink daily:

	Cups Per Day
Coffee	
Hot or Iced Tea	
Caffeinated Soft Drinks	

5. On the average, how many alcoholic beverages do you drink?
   Weekdays: _____ per day Weekends: _____per day What kind? _____
6. Have you ever smoked cigarettes? ☐Yes ☐No If yes, are you currently smoking? ☐Yes ☐No
   Average packs per day: _____ At what age did you start smoking? _____ Age Quit Smoking? _____
7. Have you experienced any of the following symptoms?

	No	Occasionally	Frequently
Feeling unable to move for a brief moment when falling asleep or waking up	☐	☐	☐
Seeing things or hearing voices that are not real when falling asleep or waking up	☐	☐	☐
Feeling sudden muscle weakness (jaw drooping, knees buckling, falling, etc) when laughing, or experiencing strong emotions (anger, surprise)	☐	☐	☐

Daytime Symptoms

1. How do you usually awaken? ☐Spontaneously ☐Alarm ☐Other _____
2. How long does it take you to feel awake in the morning? _____

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3. Do you experience any of the following:	No	Occasionally	Frequently
Waking up feeling tired and unrefreshed	☐	☐	☐
Waking up with a headache	☐	☐	☐
Waking up with a dry mouth	☐	☐	☐
Feeling excessively sleepy during the day	☐	☐	☐
Feeling physically tired during the day	☐	☐	☐
Having difficulty with concentration	☐	☐	☐
Having problems with memory	☐	☐	☐
Feeling irritable or depressed	☐	☐	☐

1. Have you had your tonsils/adenoids surgically removed? ☐Yes ☐No
   Have you ever had neck or nasal surgery/trauma? ☐Yes ☐No
   If so, please list and explain outcome: _____

2. Has anyone in your family been known to have sleep problems? ☐Yes ☐No
   If yes, please describe: _____

3. Have you ever fallen asleep while driving? ☐Yes ☐No
   Have you had an accident while driving because you were sleepy or not paying attention to the road? ☐Yes ☐No

4. If there are any other aspects of your sleep problems that are not covered by this questionnaire that you feel the provider would find helpful, please describe them here:

   _____

   _____

   _____

Epworth sleepiness score

How likely are you to fall asleep in the following situations:

0 – would never fall asleep
1 – slight chance of falling asleep
2 – moderate chance falling asleep
3 – high chance of falling asleep

	Chance of dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (like a theater)	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	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

Total _____