WEST COAST PULMONARY
& SLEEP DISORDERS CENTER

SLEEP QUESTIONNAIRE

Name: _____ Date: _____

My main sleep complaint is:

- ☐ Trouble sleeping at night
- ☐ Being sleepy all day
- ☐ Unwanted behaviors during sleep, explain: _____
- ☐ Other, explain: _____

USUAL SLEEP HABITS

Bedtime: _____ ☐ am/☐ pm
Wake time: _____ ☐ am/☐ pm

Number of awakenings: _____
Naps per week: _____
Duration of sleep problem: _____

DIRECTIONS: Check any statement which currently applies to you

- ☐ Unrefreshing naps
- ☐ Restless sleeper
- ☐ Stop breathing during sleep
- ☐ Awaken with headaches
- ☐ Have high blood pressure
- ☐ Cough up sputum or mucus at night
- ☐ Falling asleep at inappropriate times
- ☐ Refreshing naps
- ☐ Vivid dreams
- ☐ Paralysis or inability to move on awakening
- ☐ Eat excessive amounts of sweets or chocolates
- ☐ Driven miles past destination with little awareness
- ☐ Legs jerk during sleep
- ☐ Experience inability to keep legs still
- ☐ Trouble falling asleep
- ☐ Awaken long before it is necessary
- ☐ Sleep better I unfamiliar setting
- ☐ Light sleeper
- ☐ Function best in the evening
- ☐ Jaws ache in morning
- ☐ Bedwetting in adulthood
- ☐ Sudden awakening with intense anxiety or dread
- ☐ Late sleeper
- ☐ Bitter or sour mouth taste in morning
- ☐ Hiatal hernia
- ☐ Awaken with blood on the pillow
- ☐ Awaken with heartburn
- ☐ Very loud snorer
- ☐ Awaken with choking sensation
- ☐ Sweat a lot during sleep
- ☐ Difficulty waking in the morning
- ☐ Have gained more than 10 lbs. in the last year
- ☐ Unable to sleep in a flat position
- ☐ Driving accidents or near-accidents due to sleepiness
- ☐ Dream a lot
- ☐ Dreams or hallucinations while awake
- ☐ Sudden sensation of weakness in knees or legs
- ☐ Was a hyperactive child or teenager
- ☐ Kicking or twitching during sleep
- ☐ Experience restlessness, tingling or crawling in legs
- ☐ Sleep with ear plugs or eye shades
- ☐ Trouble returning to sleep
- ☐ Don't feel tired at bedtime
- ☐ Use sleeping pills
- ☐ Bed partner disturbs sleep
- ☐ Grind teeth in sleep
- ☐ Sleep walking as adult
- ☐ Banging, twisting or shaking head during sleep
- ☐ Shift-worker or night work
- ☐ Heart pain during the night
- ☐ Nocturnal seizures
- ☐ Awaken with back pain
- ☐ Bitten tongue during sleep

MEN

- ☐ Awaken with painful penile erections
- ☐ Have problems obtaining or maintaining erections

WOMEN

- ☐ Sleep problem varies with menstrual cycle
- ☐ Sleep problem started or got worse at menopause
- ☐ Currently taking birth control pills

FAMILY HISTORY

- ☐ A relative died of "crib death"
- ☐ Other family members snore loudly
- ☐ Other family members have sudden attacks of muscle weakness
- ☐ Other family members fall asleep during the day
- ☐ Other family members have the same sleep problem I do

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SPOUSE OR ROOMMATE QUESTIONNAIRE

Name of Patient: _____ Date: _____

Check any of the following behaviors that you have observed the patient doing while asleep.

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Twitching of legs or feet during sleep
- ☐ Pause in breathing
- ☐ Grinding teeth
- ☐ Sleep-talking
- ☐ Sleepwalking
- ☐ Bed-wetting
- ☐ Sitting up in bed but not awake
- ☐ Head rocking or banging
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

Describe the sleep behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

If you have heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”?

☐ Yes ■ No

Explain:

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STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP	Yes	No
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors?	☐	☐
Do you often feel **T**IRED, fatigues, or sleepy during daytime?	☐	☐
Has anyone **O**BSERVED you stop breathing during your sleep?	☐	☐
Do you have, or are you being treated for, high blood **P**RESSURE?	☐	☐

BANG		
BMI more than 35kg/m^2?	☐	☐
AGE over 50 years old?	☐	☐
NECK circumference > 16 inches (40cm)?	☐	☐
GENDER: Male?	☐	☐

TOTAL SCORE _____