

Creighton UNIVERSITY

Sleep Disorders Center

SLEEP QUESTIONNAIRE

TODAY'S DATE _____

NAME _____

DATE OF BIRTH _____

Check the items that apply in the top section of each group. Total your answers at the end of each section. If you check yes to two or more items in a section, or if you check yes to a starred () question, complete the rest of the questions in the section.*

SLEEP LOSS

Check (√) only if YES

1. Have difficulty falling asleep or staying asleep
2. Awaken too early in the morning
3. Have trouble going back to sleep when awakened
4. Feel tired upon awakening in the morning
5. Feel tense, irritable, or depressed during the day due to sleep loss

Total (√) _____ (*) _____
If (*) or 2 or more (√), then continue ↓↓

DAYTIME SLEEPINESS

Check (√) only if YES

1. Fall asleep when you don't want to (driving, at movie, talking) *
2. Have issues with work or social life due to sleepiness
3. Sleep more than 9 hours in a 24-hour period
4. Snore heavily most nights
5. Stop breathing or have shallow breathing during sleep *

Total (√) _____ (*) _____
If (*) or 2 or more (√), then continue ↓↓

NIGHTTIME DISTURBANCES

Check (√) only if YES

1. Have frequent leg jerks or legs feel uncomfortable or restless *
2. Have walked in sleep recently *
3. Often have vivid and disturbing nightmares *
4. Sometimes wet the bed at night *
5. Have recently fallen out of bed or woke with unexplained cuts or bruises *

Total (√) _____ (*) _____
If (*) or 2 or more (√), then continue ↓↓

6. Go to sleep and wake up at different times each day
7. Travel frequently disrupting sleep
8. Have trouble sleeping because of shift-work
9. Have light in the bedroom at night
10. Sleep in the bedroom at night
11. Wake up often due to bed partner, child, pet, other
12. Exercise within 2 hrs of bedtime
13. Drink beverages with caffeine in the afternoon or evening
14. Smoke before going to sleep or during the night
15. Have trouble falling asleep or staying asleep due to worry
16. Have recently experienced stress
17. During the past month, had trouble sleeping because of
 - A. coughing, gasping or choking
 - B. frequent need to urinate
 - C. feeling too hot
 - D. pain
18. Take prescription medication to get to sleep or stay asleep
19. Take over-the-counter medication to get to sleep or stay asleep
20. Drink alcohol in the evening
21. Have racing thoughts or trouble relaxing at night
22. Sleep better away from home

6. Have had an accident or near-miss because of excessive sleepiness
7. Fall asleep unintentionally
8. Are irritable during the day
9. Take naps that are planned or intentional
10. Awaken in the morning with a headache
11. Awaken in the morning with a dry mouth
12. Snore loudly
13. Have shallow breathing or stop breathing at night
14. Have muscle weakness when laughing, excited, or angry
15. Have trouble concentrating or remembering during the day
16. Awaken from sleep feeling paralyzed or unable to move
17. See, hear, or feel things when falling asleep or awakening
18. Have night sweats
19. Have restless sleep and move around a lot at night
20. Have had recent weight gain

6. Grind teeth or have worn down tooth enamel
7. Awaken with jaw pain
8. Have epilepsy or seizures in sleep
9. Frequently sleepwalk
10. Have episodes of sleepwalking that put you or another in danger
11. Thrash around in sleep
12. Awaken from sleep screaming, violent, or confused
13. Sometimes fall out of bed
14. Wake frequently with unexplained stiffness, bruises, injuries

MEDICATIONS

Check (√) only if YES

1. Are you taking medications prescribed by a doctor or any over-the-counter medications? *

If yes, please specify:
