DeFatta ENT
FACIAL PLASTIC SURGERY

SLEEP QUESTIONNAIRE

SLEEP DISORDERS CENTER
1490 RIVERS EDGE TRAIL
ALTOONA, WI 54720
(715) 930-7635

PATIENT INFORMATION:

Patient Name:_____

Date of Birth: _____

Height:_____ Weight:_____

Occupation:_____

Employer:_____

Do you work rotating or odd shifts: ☐Yes ☐No

CURRENT STATUS:

What is your primary sleep problem:_____

Any other sleep complaints:_____

Have you used any medications for sleep (list):_____

What is your usual bedtime:_____ Is it regular? ☐ Yes ☐ No

What time to you get up for the day:_____ Is it regular? ☐ Yes ☐ No

Do you sleep soundly or restlessly:_____

Place an x on the line below to represent the percent of time in bed that you are actually ASLEEP:

25% _____ 50% _____ 75% _____ 100%

SITUATION:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 work out how they would have affected you.

Circle one number for each:

0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Sitting and reading	0	1	2	3	Sitting, inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
Watching TV	0	1	2	3	As a passenger in a car for an hour without a break	0	1	2	3
Sitting quietly after lunch without alcohol	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	In a car while stopped for a few minutes in traffic	0	1	2	3
TOTAL POINTS IN ALL BOXES = _____									

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DO YOU:

Have trouble sleeping at night or your usual sleep time: ☐ Yes ☐ No
If yes, circle the number responses:

1 = minimal difficulty, 2 = moderate difficulty, 3 = severe difficulty

Have trouble falling asleep	0	1	2	3
Wake up unable to return to sleep	0	1	2	3
Wake up choking or gasping for air	0	1	2	3

Have a history of a car accident	☐ Yes	☐ No
Have a family history of excessive daytime sleepiness	☐ Yes	☐ No
Have a family history of sleep disorders	☐ Yes	☐ No
Have a family history of attention deficit disorder	☐ Yes	☐ No
Have a history of airway surgery	☐ Yes	☐ No

IF YOU HAVE TROUBLE FALLING OR STAYING ASLEEP, INDICATE THE FACTORS YOU THINK MAY CONTRIBUTE:

Physical pain or discomfort	☐ Yes	☐ No	Recently developed stress or worry	☐ Yes	☐ No
Long standing stress or worry	☐ Yes	☐ No	Position (back, side, etc.)	☐ Yes	☐ No
Trouble breathing	☐ Yes	☐ No	Location (bed, couch, etc.)	☐ Yes	☐ No
Nightmares	☐ Yes	☐ No	Situation (alone, with spouse, etc.)	☐ Yes	☐ No

DO YOU:

Snore	☐ Yes	☐ No	Have memory difficulties	☐ Yes	☐ No
Wake up with headaches	☐ Yes	☐ No	Have mood changes	☐ Yes	☐ No
Have shortness of breath awake	☐ Yes	☐ No	Have brief lapses of awareness awake	☐ Yes	☐ No
Have sexual difficulties	☐ Yes	☐ No	Fall asleep driving	☐ Yes	☐ No

DO YOU EVER EXPERIENCE:

Dreamlike visions or sounds just as you are falling asleep, but while still awake	☐ Yes	☐ No
Sudden loss of strength in your body when emotionally excited (laughing, crying, etc.)	☐ Yes	☐ No
Inability to move (paralysis) for a few seconds or minutes as you awake	☐ Yes	☐ No
Suffer from depression	☐ Yes	☐ No

How often do you nap:
☐ Never
☐ Rarely
☐ Daily
☐ Occasionally
☐ > 1 per day

Are your naps controllable: ☐ Yes ☐ No

Are your naps refreshing: ☐ Yes ☐ No

How long are your usual naps: _____

*Do **others** tell you that you:*

Stop breathing while asleep	☐ Yes	☐ No
Sit up in bed while asleep	☐ Yes	☐ No
Sleep walk	☐ Yes	☐ No
Talk in your sleep	☐ Yes	☐ No
Scream out or appear terrified while asleep	☐ Yes	☐ No
Thrash about or become violent during sleep	☐ Yes	☐ No
Grind your teeth during sleep	☐ Yes	☐ No
Have muscle jerks while falling asleep	☐ Yes	☐ No
Have muscle jerks while sleeping	☐ Yes	☐ No