Vancouver CoastalHealth
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UBCH Sleep Disorders Clinic
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New Patient In-Take Sleep Questionnaire

This questionnaire has been designed based on many years of experience in Sleep Medicine. Please respond to all questions. The information you provide is important and will assist the sleep specialist during the review of your sleep data. Your information will be treated with the utmost discretion.

Section A — Personal & Occupational Information

Date:_____

First/Last Name:_____

Date of Birth:_____ Age:_____

Male____ Female____ TG_____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed

Of children_____ Bed Partner ☐Yes ☐No Weight_____lbs/KG Height_____inches/cm

Neck circumference (if known) _____inches

Education(yrs)_____ (High School = 12yrs) Occupation_____

Please describe your work schedule. Check all that apply:

☐ Day shift ☐ Evening shift ☐ Overnight Shifts ☐ Student

☐ Rotating schedule ☐ Self-employed ☐ Unemployed/Retired/Disabled

Section B — Primary Complaint

☐ Snoring and/or stopping breathing at night

☐ Difficulty falling or staying asleep or sleeping at the desired time

☐ Tired/sleepy during the day

☐ Unusual behaviour(s) during sleep (walking, talking, etc)

☐ Other (please describe)_____

Section C Preparing for Sleep

Answer the following questions *thinking about the last 30 days*.

1. On average, how long does it usually take you to fall asleep at night? _____minutes

2. If it usually takes you more than 30 minutes to fall asleep, please indicate when this started:

☐ During the last three months ☐ More than 3 months ago, but less than one year ago

☐ More than one year ago ☐ Following an event that occurred _____months/years ago

Describe the event that proceeded you having difficulty falling asleep_____

_____

3. Which of the following do you notice when you try to fall asleep?

	Always	Often	Rarely	Never
• Coughing, difficulty breathing or feeling of suffocation				
• Paralysis (feeling that you cannot move)				
• Anxiety, worry or disturbing thoughts				
• Pain (legs, neck, chest, stomach, other)				
• Need to move legs (restlessness of your legs)				
• Twitches or cramping in your hands, feet, arms, legs				
• Heartburn				

Section D Sleep Habits

1. What time do you turn off the lights to go to sleep? _____am/pm (Weekdays) _____am/pm (Weekends)

2. What time to you get out of bed to start the day? _____am/pm (Weekdays) _____am/pm (Weekends)

3. How many hours do you think you actually sleep per night? _____hrs (Weekdays) _____hrs (Weekends)

4. Do you take naps during the daytime? ☐ Yes ☐ No

5. Do you wake up in the middle of the night? ☐ Yes ☐ No

   a) If yes, how often? ☐ Every night ☐ 3-7 days/week ☐ 1-2 days/week ☐ less and once/week

   b) What awakens you? _____

   c) What do you do when you are awake? _____

6. In which position do you usually sleep? ☐ on STOMACH ☐ on BACK ☐ on SIDE

   ☐ RAISED or SITTING ☐ No fixed position

7. Has anyone ever told you that you snore when you sleep? ☐ Yes ☐ No

   a) If yes, how loud is the snoring? ☐ Don't know ☐ Slightly louder than breathing

   ☐ As loud as talking ☐ Can be heard through doors and walls

8. Has anyone ever told you that you:

   a) Stop breathing during sleep? ☐ Never ☐ Occasionally ☐ Frequently

   b) Kick, jerk or twitch your legs during sleep? ☐ Never ☐ Occasionally ☐ Frequently

9. Do you find that you awaken and briefly cannot move? ☐ Yes ☐ No

10. Do you briefly see or hear things that don't exist when waking up or falling asleep? ☐ Yes ☐ No

11. How do you feel when you wake up in the morning?

- Tired (want to continue sleeping) ☐ Always ☐ Often ☐ Rarely ☐ Never
- Refreshed and energetic ☐ Always ☐ Often ☐ Rarely ☐ Never
- Unpleasantly dry mouth ☐ Always ☐ Often ☐ Rarely ☐ Never
- Suffer from pains and stiffness ☐ Always ☐ Often ☐ Rarely ☐ Never

Section E **Daytime Activity**

1. In the last 30 days, how likely are you to doze off or fall 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 work out how they would affect you.

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

2. Do you ever have sudden muscular weakness associated with emotion?

(e.g. while laughing or after hearing a joke)? ☐ Yes ☐ No

3. Do you ever have cramping of your legs during the daytime? ☐ Often ☐ Sometimes ☐ Never

Section F **Family History & Health**

1. Has any of your immediate family ever experienced any of the following?

	Yes	No	Relation to you
• Sleep apnea treated with surgery, dental appliance or CPAP			
• Narcolepsy			
• Loud and disturbing snoring			
• Excessive daytime sleepiness			

2. Do you suffer from any of the following? Check Yes or No to all that apply.

	Yes	No
Diabetes		
Asthma		
Hypertension		
Mental Health		
Depression		
Anxiety		
Panic Disorder		
Schizophrenia		
Other:		
Heart disease		
Coronary artery disease (heart attack/angina)		
Irregular heart beat		
Congestive heart failure		
Other:		

	Yes	No
Neurologic Disorder		
Stroke		
Seizures		
Migraine headaches		
Other:		
Kidney disease		
Anemia		
Reflux		
Nasal congestion		
Thyroid disease		
Hyperthyroid		
Hypothyroid		
Other:		

	Yes	No
Lung Disease		
Emphysema		
Lung cancer		
Other:		
Nasal, sinus, facial surgery		
For Women Only		
Regular periods		
Menopause status	**Pre**	**Post**

3. Have you ever been diagnosed or treated for a sleep disorder? ☐ Yes ☐ No

- Type of sleep disorder:_____
- When were you diagnosed? _____
- Who diagnosed you? _____

4. List all the medications you use regularly (prescription and over the counter):

Medication Name	**Daily Dosage**	**Reason for Use**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Approximately how many cups (8oz) of caffeinated beverages do you drink daily (coffee, tea, soda)? _____

6. When do you typically drink your last cup of caffeinated beverage each day? _____AM/PM

7. How many alcoholic beverages do you drink each day on average? _____

8. Do you smoke now? ☐ Yes ☐ No If yes, how many cigarettes do you smoke daily? _____/day

If no, did you ever smoke in the past? ☐ Yes ☐ No

9. Do you use recreational drugs? ☐ Yes ☐ No

If yes, what and how often?_____

10. As a result of sleepiness, have you personally experienced any of the following?

- Automobile accident with injury? ☐ Yes ☐ No
- Automobile accident without injury? ☐ Yes ☐ No
- Work accident? ☐ Yes ☐ No

11. In your own words, describe your sleep-related problem (brief summary):_____

_____
_____
_____
_____