SLEEP MEDICINE & RESEARCH CENTER
مركز طب وبحوث النوم

KAUH
مستشفى جامعة الملك عبدالعزيز
King Abdulaziz University Hospital

# Sleep Questionnaire

## Personal Information

Name: Date of birth: Sex: ☐ Male ☐ Female

Marital Status: Single Nationality: MRN (for KAUH Patients):

Height: Weight: Neck Size:

Address:

Occupation: Length of work day:

Does your work involve shift work? ☐ Yes ☐ No

Work Address:

Where did you hear about us: ☐ Physician ☐ Media Friend ☐ Other

Referring Physician: Referring Hospital:

Telephone:

Mobile:

E-mail:

How would you like to be contacted? ☐ Tel ☐ Mobile ☐ E-mail

## Main Complaint

## Instructions

The following questions relate to your usual sleep habits during the **past month only**. Your answers should indicate the most accurate reply for the **majority of days and nights in the past month**. **Please answer all questions.**

## During the past month

1. What time have you usually gone to bed at night?
2. How long (in minutes) has it usually taken you to fall asleep each night?
3. What time have you usually gotten up in the morning?
4. How many hours of actual sleep did you get at night? *(This may be different than the actual hours you spent in bed.)*
5. **Please choose the best answer for the following questions:**

1. During the past month, how many times you couldn't get to sleep within 30 minutes?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

2. During the past month, how many times you woke up in the middle of the night or early morning (before waking up time)?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

3. During the past month, how many times you had to get up to use the bathroom?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

4. During the past month, how many times you were not breathing well during sleep?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

5. During the past month, how many times did you cough or snore loudly?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

6. During the past month, how many times did you feel too cold?

○ Not during the past month ○ Less than once a week ○ Once or twice a week ○ Three or more times a week

7. During the past month, how many times did you feel too hot?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

8. During the past month, how many times did you have bad dreams?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

9. During the past month, how many times did you have pain?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

10. Are there any other reasons for being uncomfortable during sleep? Please describe

During the past month; how many times you couldn't sleep because of what your mentioned?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

6. During the past month, how would you rate your sleep quality overall?

| Very good | Fairly good | Fairly bad | Very bad |
|---|---|---|---|

7. During the past month how often have you taken medicine to help you sleep?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

8. During the past month, how often have you had trouble staying awake while driving, eating meals or engaging in social activity?

| Not during the past month | Less than once a week | Once or twice a week | Three or more times a week |
|---|---|---|---|

9. In the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

| No problem at all | Only a very slight problem | Somewhat of a problem | A very big problem |
|---|---|---|---|

10. Do you have a bed partner or roommate?

| I don't have | I have a partner in another room | I have a roommate in a different bed | I have a bed partner |
|---|---|---|---|

**If you have a roommate or bed partner, ask him/her how often in the past month these situations have happened**

1. Loud snoring

Not during the past month | Less than once a week | Once or twice a week | Three or more times a week

2. Long pauses between breaths while asleep

Not during the past month | Less than once a week | Once or twice a week | Three or more times a week

3. Legs twitching or jerking while asleep

Not during the past month | Less than once a week | Once or twice a week | Three or more times a week

4. Episodes of disorientation or confusion during sleep

Not during the past month | Less than once a week | Once or twice a week | Three or more times a week

5. Other restlessness while you sleep; please describe

6. How many times did this happen during the past month?

Not during the past month | Less than once a week | Once or twice a week | Three or more times a week

## Questions about your behavior during sleep and wake times

1. Have you ever been told that you snore?
   - ○ Yes
   - ○ No  If no, skip to Question 3.

2. According to what others have told you, please estimate how often you snore.
   - ○ 0. Rare1y --on1y once or a few times ever.
   - ○ 1. Sometimes – a few nights per month.
   - ○ 2. At least once a week, but pattern may be irregular.
   - ○ 3. Several (3 to 5) nights per week.
   - ○ 4. Every night or almost every night

3. Aside from what others have told you, how often, if ever, have you had the feeling or awareness that you have been snoring?
   - ○ 0. Never.
   - ○ 1. Rarely -- only once or a few times ever.
   - ○ 2. Sometimes -- a few nights per month.
   - ○ 3. Often -- at least once a week, but pattern may be irregular.
   - ○ 4. Very often -- every night or almost every night.

4. According to what others have told you, how often, if ever, do you gasp, choke, or make snorting sounds during sleep?
   - ○ 0. Never.
   - ○ 1. Rarely -- only once or a few times ever.
   - ○ 2. Sometimes -- a few nights per month.
   - ○ 3. Often -- at least once a week, but pattern may be irregular.
   - ○ 4. Very often -- every night or almost every night.

5. How often, if ever, have you awakened suddenly with the feeling of gasping or choking?
   - ○ 0. Never.
   - ○ 1. Rarely -- only once or a few times ever.
   - ○ 2. Sometimes -- a few nights per month.
   - ○ 3. Often -- at least once a week, but pattern may be irregular.
   - ○ 4. Very often -- every night or almost every night.

6. According to what others have told you, how often, if ever, do you seem to have momentary periods during sleep when you stop breathing or you breathe abnormally?
   - ○ 0. Never.
   - ○ 1. Rarely -- only once or a few times ever.
   - ○ 2. Sometimes -- a few nights per month.
   - ○ 3. Often -- at least once a week, but pattern may be irregular.
   - ○ 4. Very often -- every night or almost every night.

7. According to what others have told you, how often, if ever, do you kick or make other disruptive movements during sleep?

- ○ 0. Never.
- ○ 1. Rarely -- only once or a few times ever.
- ○ 2. Sometimes -- a few nights per month.
- ○ 3. Often -- at least once a week, but pattern may be irregular.
- ○ 4. Very often -- every night or almost every night.

8. How likely are you to dose 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.

| **Situation** | **Chance of dozing** | | | |
|---|---|---|---|---|
| | No chance of dosing (0) | Slight chance of dosing (1) | Moderate chance of dosing (2) | High chance of dosing (3) |
| Sitting and reading | ○ | ○ | ○ | ○ |
| Watching TV | ○ | ○ | ○ | ○ |
| Sitting inactive in a public place (e.g. a lecture or a meeting) | ○ | ○ | ○ | ○ |
| 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 | ○ | ○ | ○ | ○ |
| In a car, while stopped for a few minutes in traffic | ○ | ○ | ○ | ○ |

9. During the past month, have you had the following complaints?

| Condition | Yes | No |
|---|---|---|
| Had trouble sleeping because you felt an urge to move your legs, usually accompanied or caused by uncomfortable and unpleasant sensations in the legs. | ◯ | ◯ |
| You felt the urge to move, or unpleasant sensations that begin or worsen during periods of rest or inactivity such as lying or sitting. | ◯ | ◯ |
| You felt the urge to move, or unpleasant sensations that are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues. | ◯ | ◯ |
| You felt the urge to move, or unpleasant sensations that are worse in the evening or night than during the day or only occur in the evening or night. | ◯ | ◯ |
| Any similar family history? | ◯ | ◯ |

10. Do you ever wake up and feel paralyzed?
◯ Every night ◯ Occasionally ◯ Never

11. When you are angry or excited or laughing, do you feel a generalized sensation of weakness especially at the knees ?
◯ Every night ◯ Occasionally ◯ Never

12. Has your nose ever been broken ◯ Yes ◯ No
If yes , when ?

13. Can you breathe well through both nostrils? ◯ Yes ◯ No

14. How much coffee/tea/cola do you drink per day?

| Type of Drink | Number of Cups |
|---|---|
| Coffee | |
| Tea | |
| Cola | |

15. Please check whether or not you have been told by a doctor that you had or have each condition below:

| Condition | Told by a doctor | Not told by a doctor |
|---|---|---|
| Apnea (a condition where breathing stops momentarily during sleep) | ◯ | ◯ |
| Narcolepsy (inability to stay awake) | ◯ | ◯ |
| Emphysema or COPD | ◯ | ◯ |
| Chronic Bronchitis or Asthma | ◯ | ◯ |
| Allergic Rhinitis | ◯ | ◯ |
| Angina or Coronary Heart Disease or Arteriosclerosis | ◯ | ◯ |
| Heart attack | ◯ | ◯ |
| Stroke | ◯ | ◯ |
| Hypertension or High Blood Pressure | ◯ | ◯ |
| Diabetes | ◯ | ◯ |
| Hypothyroidism | ◯ | ◯ |
| Others | ◯ | ◯ |

16. Do you take any medication?
If yes please list all medications you are currently taking:

| Medication | Dosage | Reason | Since when |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please Circle the one response to each item that best describes you for the past seven days**

## 1. Falling Asleep:

- 0. I never take longer than 30 minutes to fall asleep.
- 1. I take at least 30 minutes to fall asleep less than half the time.
- 2. I take at least 30 minutes to fall asleep more than half the time.
- 3. I take more than 60 minutes to fall asleep more than half the time.

## 2. Sleep During the Night:

- 0. I do not wake at night.
- 1. I have a restless, light sleep with a few brief awakenings each night.
- 2. I wake up at least once a night, but I go back to sleep easily.
- 3. I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

## 3. Waking Up Too Early:

- 0. Most of the time, I awaken no more than 30 minutes before I need to get up.
- 1. More than half the time, I awaken more than 30 minutes before I need to get up.
- 2. I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- 3. I awaken at least one hour before I need to and can't go back to sleep.

## 4. Sleeping Too Much:

- 0. I sleep no longer than 7-8 hours/night, without napping during the day.
- 1. I sleep no longer than 10 hours in a 24-hour period including naps.
- 2. I sleep no longer than 12 hours in a 24-hour period including naps.
- 3. I sleep longer than 12 hours in a 24-hour period including naps.

## 5. Feeling Sad:

- 0. I do not feel sad.
- 1. I feel sad less than half the time.
- 2. I feel sad more than half the time.
- 3. I feel sad nearly all the time.

## 6. Decreased Appetite:

- 0. My usual appetite has not decreased.
- 1. I eat somewhat less often or lesser amounts of food than usual.
- 2. I eat much less than usual and only with personal effort.
- 3. I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

## 7. Increased Appetite:

- 0. My usual appetite has not increased.
- 1. I feel a need to eat more frequently than usual.
- 2. I regularly eat more often and/or greater amounts of food than usual.
- 3. I feel driven to overeat both at mealtime and between meals.

**8. Decreased Weight (within the last 2 weeks):**

- 0. My weight has not decreased.
- 1. I feel as if I've had a slight weight loss.
- 2. I have lost 2 pounds or more.
- 3. I have lost 5 pounds or more.

**9. Increased Weight (within the last 2 weeks):**

- 0. I have not had a change in my weight
- 1. I feel as if I've had a slight weight gain.
- 2. I have gained 2 pounds or more.
- 3. I have gained 5 pounds or more.

**10. Concentration/Decision Making:**

- 0. There is no change in my usual capacity to concentrate or make decisions.
- 1. I occasionally feel indecisive or find that my attention wanders.
- 2. Most of the time, I struggle to focus my attention or to make decisions.
- 3. I cannot concentrate well enough to read or cannot make even minor decisions.

**11. View of Myself:**

- 0. I see myself as equally worthwhile and deserving as other people.
- 1. I am more self-blaming than usual.
- 2. I largely believe that I cause problems for others.
- 3. I think almost constantly about major and minor defects in myself.

**12. Thoughts of Suicide or Death:**

- 0. I do not think of suicide or death.
- 1. I feel that life is empty or wonder if it's worth living.
- 2. I think of suicide or death several times a week for several minutes.
- 3. I think of suicide or death several times a day in some detail or have actually tried to take my life.

**13. General Interest:**

- 0. There is no change from usual in how interested I am in other people or activities.
- 1. I notice that I am less interested in people or activities.
- 2. I find I have interest in only one or two of my formerly pursued activities.
- 3. I have virtually no interest in formerly pursued activities.

**14. Energy Level:**

- 0. There is no change in my usual level of energy.
- 1. I get tired more easily than usual.
- 2. I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).
- 3. I really cannot carry out most of my usual daily activities because I just do not have the energy.

## 15. Feeling Slowed Down:

- ○ 0. I think, speak and move at my usual rate of speed.
- ○ 1. I find that my thinking is slowed down or my voice sounds dull or flat.
- ○ 2. It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- ○ 3. I am often unable to respond to questions without extreme effort.

## 16. Feeling Restless:

- ○ 0. I do not feel restless.
- ○ 1. I'm often fidgety, wring my hands, or need to shift how I am sitting.
- ○ 2. I have impulses to move about and am quite restless.
- ○ 3. At times, I am unable to stay seated and need to pace around.