



Exam 7

Sleep Questionnaire

Participant ID #:
Acrostic:
Technician ID:
Date: / /
Month Day Year

The following questions are about your sleep. Please consider both what others have told you about your sleep and what you know yourself.

1. How much sleep do you usually get each night (or over the longest time you are in bed)?

hours minutes

2. Have you had problems falling asleep, staying asleep, or waking up too early that occurred three or more times per week and lasted 3 or months?

- Yes →
- No

a. If yes, when did these problems first start?

- In the last year
- Between one and 5 years ago
- Between 5 and 10 years ago
- More than 10 years ago

b Do you currently have problems with falling asleep, staying asleep, or waking too early?

- Yes
- No

3. Overall, how was your typical night's sleep during the **past 4 weeks**?

- Very sound or restful
- Sound and restful
- Average quality
- Restless
- Very Restless

4. Do you feel your sleep has changed over the **past five years**?

- Definitely much worse
- Somewhat worse
- A little worse
- About the same
- Somewhat better
- Definitely much better



Exam 7

Sleep Questionnaire

5. Over the **past 4 weeks**, how often have you snored?

- Never
- Rarely (1-2 nights a week)
- Sometimes (3-5 nights a week)
- Always or almost always (6-7 nights a week)
- Don't know

6. Over the **past 4 weeks**, how often have you had times when you stopped breathing during your sleep?

- Never
- Rarely (1-2 nights a week)
- Sometimes (3-5 nights a week)
- Always or almost always (6-7 nights a week)
- Don't know

7. Do you ever experience a desire to move your legs because of discomfort or disagreeable sensations in your legs?

- Yes
- No
- Don't know

a. Do you sometimes feel the need to move to relieve the discomfort, for example by walking, or by rubbing your legs?

- Yes
- No
- Don't know

b. Are these symptoms worse when you are at rest, with at least temporary relief by activity?

- Yes
- No
- Don't know

c. Are these symptoms worse later in the day or at night?

- Yes
- No
- Don't know

8. How likely are you to doze off or fall asleep during the daytime when you don't mean to?

- | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|
| Never | Sometimes | Often | All of the time |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Exam 7

Sleep Questionnaire

9. Many people are more alert in the mornings and consider themselves to be morning people. Others are most alert in the evenings and consider themselves to be evening people. What do you consider yourself to be?

- Definitely a morning person
- More a morning than an evening person
- More an evening than a morning person
- Definitely an evening person
- Neither a "morning" nor an "evening" type

The following questions ask about diagnosed sleep disorders.

Have you been told by a doctor or other health care provider that you have any of the following:

10. Sleep apnea (or obstructive sleep apnea, OSA)? Yes No

<i>If yes:</i> Do you use any of the following for your sleep apnea?	Yes	No	<i>If yes:</i> About how many nights a week do you use this?
A pressure machine such as CPAP, APAP, or BiLevel?	<input type="radio"/>	<input type="radio"/>	_____
A dental device during sleep (a device put in your mouth at night that moves the jaws open)?	<input type="radio"/>	<input type="radio"/>	_____
Oxygen during sleep?	<input type="radio"/>	<input type="radio"/>	_____

11. Insomnia? Yes No

<i>If yes:</i> Do you use any of the following for your insomnia?	Yes	No	<i>If yes:</i> About how many nights a week do you use this?
Over the counter medications?	<input type="radio"/>	<input type="radio"/>	_____
Prescription sleeping pills (such as trazadone, Ambien)?	<input type="radio"/>	<input type="radio"/>	_____

12. Restless legs? Yes No



Exam 7

Sleep Questionnaire

13. Which of the following best describes your usual work schedule?

- Day shift
- Afternoon shift
- Night shift
- Split shift
- Irregular shift / On-call
- Rotating shifts
- Don't work

The following questions ask about feeling sleepy or alert during the day.

In the last 7 days...

Not at all A little bit Somewhat Quite a bit Very much

14. I had a hard time getting things done because I was sleepy.

15. I felt alert when I woke up.

16. I felt tired.

17. I had problems during the day because of poor sleep.

18. I had a hard time concentrating because of poor sleep.

19. Questionnaire completed by:

- Participant
- Proxy