Etobicoke Brampton Sleep Clinic

Sleep Disorder Screening Questionnaire

Name: _____ Date: _____

SNORING

- Do you snore?..... Yes No
- I have been told that I am a loud snorer..... Yes No
- I snore more loudly when I sleep on my back..... Yes No

OBSTRUCTIVE SLEEP APNEA AND DAYTIME SLEEPINESS

- I have been told that I sometimes stop breathing during sleep..... Yes No
- I sometimes wake up short of breath or gasping for air..... Yes No
- I feel that I lack energy; I feel tired and/or un-refreshed..... Yes No
- I frequently feel sleepy during the day..... Yes No
- Daytime sleepiness interferes with my job..... Yes No
- Daytime sleepiness interferes with my enjoyment of life..... Yes No
- I have trouble remembering things..... Yes No
- I have difficulty concentrating at work..... Yes No
- People tell me that I am often cranky or irritable..... Yes No
- I sweat excessively during the night..... Yes No
- I wake up in the morning with a headache..... Yes No
- My mouth is dry when I wake up in the morning..... Yes No
- I am overweight..... Yes No
- I have been experiencing impotence..... Yes No

SLEEP HYGIENE AND SLEEP SCHEDULE DISORDERS

- I have regular sleeping hours..... Yes No
- I usually sleep for less than 7 hours_____ More than 9 hours_____
- My job involves shift work or working unusual hours..... Yes No

- I don't have time to get the sleep I need..... Yes No
- I fall asleep approximately at _____ I get up at_____
- I take a nap during the day: Yes No How long_____

INSOMNIA, DEPRESSION, ANXIETY

- I have difficulty falling asleep at night..... Yes No
- It takes me more than 30 min to fall asleep..... Yes No
- I tend to worry about thing and have troubled relaxing..... Yes No
- Thoughts racing through my mind often prevent me from falling sleep..... Yes No
- I wake up frequently during the night..... Yes No
- If I wake up at night, I have trouble falling back to sleep..... Yes No
- I regularly take something in the evening to help me sleep..... Yes No
- I suffer from pain during the night..... Yes No
- I suffer from depression..... Yes No
- I suffer from chronic anxiety..... Yes No
- I take tranquilizers or anti-depressants..... Yes No

RESTLESS LEGS AND PERIODIC LEG MOVEMENTS

- Sometimes I cannot keep my legs still..... Yes No
- I have a crawling sensation in my legs. The legs feel restless, numb, hot or cold. I have the need to move them.....Yes No
- I have been told that my arms or legs kick or jerk during sleep..... Yes No
- I am restless sleeper..... Yes No
- I lack Iron.....Yes No

NARCOLEPSY

- I have experienced unexplained weakness somewhere in my body..... Yes No
- I have felt weakness in my body when I laugh or I am upset.....Yes No
- Sometimes just as I am falling asleep or as I am waking up, I feel that my muscles

are "paralyzed" for a few minutes..... Yes No

- I have vivid dreams just as I am falling asleep or waking up..... Yes No
- I have vivid dream during naps..... Yes No
- Sometimes I see things that are not really there..... Yes No
- There are times when I have an irresistible urge to sleep..... Yes No
- I feel more energetic after taking a nap..... Yes No

PARASOMNIA

- I have a history of sleep talking..... Yes No
- I have history of sleep walking..... Yes No
- I have gone to the kitchen and ate some food without waking up..... Yes No
- I suffer from nightmares..... Yes No
- I "act out" my dream and have injured myself or others..... Yes No

ACID REFLUX

- I have heartburn or an acid taste in my mouth during the night..... Yes No
- I sometimes wake up at night coughing or wheezing..... Yes No

SOCIAL HABITS

- Alcohol use: Never Occasionally Regularly
- Caffeine intake (Coffee, Tea, Cola): Never or _____ cups/cans per day

My last cup/can today was at_____

- I smoke cigarettes.....Yes No Other.....Yes No

I SUFFER FROM:

Diabetes	High blood pressure	Heart Disease
History of Stroke	Seizures	Parkinson disease
Asthma	Other lung disease	

Other disease (Please explain):