SLEEP HISTORY QUESTIONNAIRE

A. GENERAL INFORMATION

Name: _____ Date: _____

Age: _____

Gender: Female Male Other _____ (circle one)

Education (years of school): _____

Occupation: _____

Relationship Status: married/partnered single divorced live with someone

widowed other: _____ (circle one)

Are you a caregiver for someone (e.g., parents, children) who lives in your home? Yes No
If so, whom so you care for:_____

_____

B. SLEEP HISTORY

1. Please describe your main sleep concern(s).

_____

_____

_____

2. How long have you had this problem? _____

3. Has your sleep problem increased in severity, and if so, over what period of time? _____

_____

4. What do you feel is the major cause(s) of your sleep problem?

_____

_____

_____

5. Have you ever had your sleep recorded overnight in a sleep laboratory or at home? Yes No

If yes, please give details and describe the findings if you are aware of them.

_____

_____

_____

6. Do you have a current diagnosis of sleep apnea? Yes No (circle one)

If Yes, do you use a positive airway pressure (CPAP/BiPAP) machine? Yes No

How many hours per night? _____ How many nights per week? _____

If you have a CPAP/BiPAP machine but are not using it, what is the reason? _____

_____

7. What is your goal in regard to your sleep?

_____

_____

8. How many times do you wake up during the night…

a) on a good night? _____times b) on a bad night? _____times

9. After initially falling asleep, how many minutes do you spend awake during the night?

a) on a good night? _____min b) on a bad night? _____min

10. Do you nap or doze off during the day? Yes No (circle one)

If yes, how many times per week do you nap? _____times per week

How many minutes long is your typical nap? _____ minutes

11. Is there anything in your environment that disrupts your sleep? (Examples may include pets, bed partner, children, noises, light, uncomfortable bed, etc.) Yes No (circle one)

If yes, please describe: _____

_____

12. Indicate how many times per month you have noticed that you…

a) Wake up with a morning headache _____ times per month

b) Have an uncontrollable urge to move your legs or unpleasant/uncomfortable sensations in your legs that occur *in the evening* _____ times per month

c) Sleepwalk during the night _____ times per month

d) Grind your teeth during sleep _____ times per month

e) Have episodes of feeling paralyzed during sleep or immediately on waking _____ times per month

f) Have nightmares (upsetting or distressing dreams) _____ times per month

g) Other unusual behaviors during sleep (please describe) _____ times per month

_____

_____

13. What is your typical work schedule? (select all that apply)

☐ day shift ☐ evening shift ☐ night shift ☐ rotating shift ☐ do not work (retired/disabled)

14. Thinking about the time of day that you feel best (at your peak performance), do you consider yourself to be: (choose one)

☐ a "morning" person ☐ an "evening" person ("night owl") ☐ neither/somewhere in between

C. MEDICATIONS/MEDICAL HISTORY

1. Currently, how many times during the month do you use medications/supplements (either prescription or over-the-counter) **to help you sleep**?

Name of medication(s):_____ Number of times per month: _____

_____ _____

_____ _____

2. Do you drink alcohol **to help you sleep**? Yes No (circle one)

If Yes, please indicate how much and how often below:

a) Beer: _____(ounces) _____ (times per month)

b) Wine: _____(ounces) _____ (times per month)

c) Liquor: _____(ounces) _____ (times per month)

d) Other: _____(ounces) _____ (times per month)

How long have you been using alcohol for sleep? _____ (months or years?)

3. How much of the following do you consume (use/take in) during the average day?

a) Alcohol _____(ounces)

b) Coffee (with caffeine) _____(cups: 1 cup = 8 oz.)

c) Tea (with caffeine) _____(cups: 1 cup = 8 oz.)

d) Soft drink (with caffeine) _____(ounces)

e) Energy drinks (with caffeine) _____(ounces)

f) Cigarettes _____(packs per day)

g) Other tobacco products _____

h) Non-prescription substances (recreational drugs)_____

4. Please list any medications, prescribed and over-the-counter.

Medication Dosage/times per day Reason

_____

_____

_____

_____

5. Have you ever been treated by a psychiatrist, psychologist, or other mental health professional?

   Yes No (circle one). If yes, please indicate when you were treated and for what reason.

   _____

   _____

6. Has anyone in your family ever had problems with sleep? If yes, please describe below:

   _____

   _____

7. OTHER INFORMATION. In the space provided below, please add any information that you feel is important.

_____

_____

_____

_____

BERLIN QUESTIONNAIRE

Please choose the correct response to each question.

1. **Do you snore?**

_____ a. Yes
_____ b. No
_____ c. Don't know

★**If you snore:**

2. **Your snoring is:**

_____a. Slightly louder than breathing
_____b. As loud as talking
_____c. Louder than talking
_____d. Very loud – can be heard in adjacent rooms

3. **How often do you snore?**

_____a. Nearly every day
_____b. 3-4 times a week
_____c. 1-2 times a week
_____d. 1-2 times a month
_____e. Never or nearly never

4. **Has your snoring ever bothered other people?**

_____a. Yes
_____b. No
_____c. Don't Know

5. **Has anyone noticed that you quit breathing during your sleep?**

_____a. Nearly every day
_____b. 3-4 times a week
_____c. 1-2 times a week
_____d. 1-2 times a month
_____e. Never or nearly never

6. **How often do you feel tired or fatigued after your sleep?**

_____a. Nearly every day

_____b. 3-4 times a week

_____c. 1-2 times a week

_____d. 1-2 times a month

_____e. Never or nearly never

7. **During your waking time, do you feel tired, fatigued or not up to par?**

_____a. Nearly every day

_____b. 3-4 times a week

_____c. 1-2 times a week

_____d. 1-2 times a month

_____e. Never or nearly never

8. **Have you ever nodded off or fallen asleep while driving a vehicle?**

_____a. Yes

_____b. No

★**If yes:**

9. **How often does this occur?**

_____a. Nearly every day

_____b. 3-4 times a week

_____c. 1-2 times a week

_____d. 1-2 times a month

_____e. Never or nearly never

10. **Do you have high blood pressure?**

_____a. Yes

_____b. No

_____c. Do not know

For clinic use only:
Cat 1: ____ +/-
Cat 2: ____ +/-
Cat 3: ____ +/-
Risk: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to (or when) 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. Use the following scale to choose the most appropriate number for each situation:

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

Situation (what you were doing at the time)	**Chance of dozing**
Sitting and reading	_____
Watching TV	**_____**
Sitting inactive in a public place (e.g. a theater 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 without alcohol	_____
In a car, while stopped for a few minutes in the traffic	**_____**

Insomnia Severity Index

For each question, please *CIRCLE* the number that best describes your answer.

Please rate the *CURRENT (i.e. LAST 2 WEEKS) SEVERITY* of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing (limiting or effecting) the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

PITTSBURGH SLEEP QUALITY INDEX

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.

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1. During the past month, what time have you usually gone to bed at night?

BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .

a) Cannot 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_____

b) Wake up in the middle of the night or early morning

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

c) Have 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_____

d) Cannot breathe comfortably

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

e) 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_____

f) Feel too cold

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

g) Feel too hot

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

h) Had bad dreams

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

i) Have pain

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

j) Other reason(s), please describe_____

_____

How often during the past month have you had trouble sleeping because of this?

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 (prescribed or "over the counter")?

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. During 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 _____

For clinic use only:

DURAT: _____

DISTIB: _____

LATEN: _____

DAYDYS: _____

HSE: _____

QUAL: _____

MEDS: _____

TOTAL: _____

Buysse DJ, Reynolds CF, Monk TH, Berman SR, Kupfer DJ: Psychiatry Research, 28:193-213, 1989.

PSQI Addendum

INSTRUCTIONS:

Please answer the following additional questions regarding your sleep in the past month. Include any observations from your bed partner/roommate.

1. During the **past month**, how often have you had trouble sleeping because you...

a) Feel hot flashes:

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

b) Feel general nervousness:

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

c) Had memories or nightmares of a traumatic experience:

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

d) Had severe anxiety or panic, not related to traumatic memories:

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

e) Had bad dreams, not related to traumatic memories:

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

f) Had episodes of terror or screaming during sleep without fully awakening:

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

g) Had episodes of "acting out" your dreams, such as kicking, punching, running, or screaming:

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

2. If you had memories or nightmares of a traumatic experience during sleep (question 1-c above)....

a) How much anxiety did you feel during the memories/nightmares?

None_____ Very little_____ Moderate_____ Severe_____

b) How much anger did you feel during the memories/nightmares?

None_____ Very little_____ Moderate_____ Severe_____

c) What time of night did most memories/nightmares occur?

Early in the night____ Middle of the night_____ Late night, near morning_____ No particular time_____

 Germain A, Hall M, Krakow B, Shear MK Buysse DJ: Anxiety Disorders, 19:233-244, 2005.

Sleep Hygiene Index

Please rate all of the following statements using the scale below.

5 Always
4 Frequently
3 Sometimes
2 Rarely
1 Never

		1=Never	2=Rarely	3=Sometimes	4=Frequently	5=Always
Sleep Hygiene Index						
Please circle the number or blacken the box by using the scale above.						
1.	I take daytime naps lasting two or more hours.	1	2	3	4	5
2.	I go to bed at different times from day to day.	1	2	3	4	5
3.	I get out of bed at different times from day to day.	1	2	3	4	5
4.	I exercise to the point of sweating within one hour of going to bed.	1	2	3	4	5
5.	I stay in bed longer than I should two or three times a week.	1	2	3	4	5
6.	I use alcohol, tobacco, or caffeine within four hours of going to bed or after going to bed.	1	2	3	4	5
7.	I do something that may wake me up before bedtime (for example: play video games, use the internet, or clean).	1	2	3	4	5
8.	I go to bed feeling stressed, angry, upset, or nervous.	1	2	3	4	5
9.	I use my bed for things other than sleeping or sex (for example: watch television, read, eat, or study).	1	2	3	4	5
10.	I sleep on an uncomfortable bed (for example: poor mattress or pillow, too much or not enough blankets).	1	2	3	4	5
11.	I sleep in an uncomfortable bedroom (for example: too bright, too stuffy, too hot, too cold, or too noisy).	1	2	3	4	5
12.	I do important work before bedtime (for example: pay bills, schedule, or study).	1	2	3	4	5
13.	I think, plan, or worry when I am in bed.	1	2	3	4	5

University of Arkansas at Little Rock ● Biobehavioral Laboratory David F. Mastin, Jeff Bryson and Robert Corwyn, Assessment of Sleep Hygiene Using the Sleep Hygiene Index, Journal of Behavioral Medicine, Vol. 29, No. 3, June 2006.