Hinsdale Sleep Center

Breathe Better, Hear Better, Sleep Better

908 N. Elm Street, Hinsdale, Illinois 60521

Telephone: 630-528-9999 Fax: 630-427-6525

Patient Sleep Questionnaire

Demographics

Patient Name: ____ Date: _______________ Patient ID: ________________

Date of Birth: _______________ Age: __________ Height: ___________ Weight: ___________ Gender: ____________

Marital Status: (S M W D) Occupation: ____

Sleep Complaint

1. Briefly describe your sleep complaint: ____

   ____

Sleep Schedule

2. What is your normal bedtime? ____
3. What is your normal wake time? ____
4. How long does it take you to fall asleep? ____
5. How many times do you wake up throughout the night? ____
6. How often do you usually nap? ☐ Never ☐ Little ☐ Weekly ☐ 2-3 times/wk ☐ Daily

Social History

7. How often do you usually exercise? ☐ Never ☐ Little ☐ Weekly ☐ 2-3 times/wk ☐ Daily
8. Do you smoke cigarettes *or* have you smoked in the past? ☐ Yes ☐ No

If Yes: How long have you smoked? __________________________________ (Indicate in years or months)

How much do you smoke per day? __________________________________ (Indicate cigarettes or packs)

If you quit, when did you stop? __________________________________ (Indicate in years or months)

9. Do you drink alcohol? ☐ Yes ☐ No

If Yes, indicate at what time(s) and how much? ____

10. Do you drink anything with caffeine regularly? ☐ Yes ☐ No *(This includes coffee, tea, pop, energy drinks)*

If Yes, indicate type and at what time(s) throughout the day: ____

Medical History

11. Please list all current and/or past diagnoses: ____

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12. Please list all current and/or past medications: ____

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13. Please list any allergies: ____

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14. Have you undergone upper airway or sinus surgeries? ☐ Yes ☐ No

If Yes, please describe any surgeries performed on the nose, mouth, throat, neck or head: __________________________

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15. Does anyone in your family snore or have any sleep conditions? ☐ Yes ☐ No

If Yes, please indicate, and their relationship to you (e.g. mother, father, brother, etc.): ____________________________

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Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits. 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. Problems 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 the quality of 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 all day/daily chores, concentration, memory, mood, etc.) CURRENTLY?

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

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = ____________________ your total score.

Epworth Sleepiness Scale

16. *Check box with most appropriate answer:*

Please indicate how likely you are to fall asleep in each situation	**No Chance (0)**	**Slight Chance (1)**	**Moderate Chance (2)**	**High Chance (3)**
17. Sitting and Reading				
18. Watching TV				
19. Sitting inactive in a public place (e.g. theater, meeting)				
20. As a passenger in a car for an hour with a break				
21. Lying down to rest in the afternoon when circumstances permit				
22. Sitting and talking to someone				
23. Sitting quietly after lunch without alcohol				
24. In a car, while stopped for a few minutes in traffic				

____ ____________________

Patient Signature **Date**

____ ____________________

Hinsdale Sleep Center Staff Signature **Date**

25. How many hours of sleep do you typically get per night? ____

26. When do you usually feel at your best? ☐ Morning ☐ Evening
27. Does you sleep schedule change during weekends? ☐ Yes ☐ No

If Yes, indicate weekend bed and wake time? ____

Total score categories:
0-7 = *No clinically significant insomnia*
8-14 = *Subthreshold insomnia*
15-21 = *Clinical insomnia (moderate severity)*
22-28 = *Clinical insomnia (severe)*

Other Comments

Please describe any other information you feel may affect your sleep or treatment with us: ____________________

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