DRS. GIRGIS & ASSOCIATES
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Hinsdale Sleep Center

Sleep Questionnaire

Demographics:

Patient Name: _____ Date: _____ Pt Acct# _____

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:

1. How often do you usually exercise? ☐ Never ☐ Little ☐ Weekly ☐ 2-3 times/wk ☐ Daily
2. 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)

3. Do you drink alcohol? ☐ Yes ☐ No

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

4. 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: _____

Insomnia Severity Index: *Please circle the appropriate response for each item. "**CURRENT" is meant to refer to the last 2 weeks.***

Please rate the CURRENT severity of each sleep problem listed below.	**None/Not Applicable**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Waking up earlier than intended	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. 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	**A Little**	**Somewhat**	**Much**	**Very Much**
0	**1**	**2**	**3**	**4**

6. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

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

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

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

Total Score on the Insomnia Severity Index: _____

Epworth Sleepiness Scale: *Please answer the questions below by checking the box that best describes you, based on how likely you are to fall asleep or doze in each situation **during the last 2 weeks.***

Chance of Falling Asleep or Dozing ***Place a check mark in the appropriate box to the right for each item.***	**No Chance (0)**	**Slight Chance (1)**	**Moderate Chance (2)**	**High Chance (3)**
1. Sitting and reading				
2. Watching TV				
3. Sitting inactive in a public place (e.g. theater, meeting)				
4. As a passenger in a car for an hour without a break				
5. Lying down to rest in the afternoon when circumstances permit				
6. Sitting and talking to someone				
7. Sitting quietly after lunch without alcohol				
8. In a car, while stopped for a few minutes in traffic				

Total Score on the Epworth Sleepiness Scale: _____