THE CENTER FOR SLEEP DISORDERS
GW- MEDICAL FACULTY ASSOCIATES

SLEEP DISORDERS INVENTORY

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Please provide the following information:

Name: _____ Date: _____
Age: _____ Birth Date: _____ Weight: _____ Height: _____ BMI _____

Instructions: The following questions will help us understand any sleep problems you may have. Please answer all of the questions to the best of your ability. For some questions, you should *circle* YES if the item is true for you or NO if the item does not apply to you. For other questions, a space is provided for you to write a number, such as how many minutes it takes you to fall asleep. For all questions, give an answer that is the closest to the truth, as you know it. For some questions, you may have to ask someone who has seen you sleep; if no one has seen you sleep, write DK (don't know).

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1. What is your primary sleep problem? _____
How long have you had that problem? _____No. Years; _____No. Months; _____No. Weeks _____

2. What is your marital status? ……..……Married ____ Single ____ Divorced ____ Separated ____

3. Do you have children? ……YES NO
If YES, what are their ages? ……....._____

4. At what time do you usually turn out the lights to go to sleep? _____
At what time do you usually wake up for the next day? _____

5. How many minutes does it usually take you to fall asleep?……....._____

6. How many nights a week do you get 9 or more hours sleep? ……....._____
How many nights a week do you get 8 hours sleep?……....._____
How many nights a week do you get 7 hours sleep?……....._____
How many nights a week do you get 6 hours sleep?……....._____
How many nights a week do you get 5 or less hours sleep?……....._____

5. Do you take 30 minutes or more to fall asleep, more that once a week?…….....YES NO
If YES: How many nights does this happen each week ?……..._____
On nights when you have this problem how many minutes does it take you to fall asleep?……...._____
On nights when you have this problem, how many hours do you sleep?……..._____

6. Do you wake up during the night and take 20 minutes or more to regain sleep, more than once a week?.....YES NO
If YES: How many nights does this happen each week?……....._____

On average, how many times does this happen each night?……....._____
How many minutes does it take you to fall back asleep each time?……..._____..
On nights when you have this problem, how many hours do you sleep?……....._____.

7. Do you often wake up in the morning before your scheduled wake time, and cannot go back to sleep?……..YES NO
   If YES: How many nights each week do you have this problem?……....._____
   On nights when you have this problem, how many hours do you sleep?……_____

8. Are you sleepy during the day?…… YES NO

9. Do you often fall asleep at inappropriate times or places during the day because you are not getting enough sleep?…….....YES NO

10. Do you often have trouble functioning during the day because you are not getting enough sleep?……..YES NO

11. On nights when you do get a full night's sleep, do you still:
    - Have trouble waking up, or wake up feeling unrefreshed?……YES NO
    - Fall asleep involuntarily during the day, but only when somewhat unstimulated?……YES NO
      If YES, check each example that applies to you: While watching TV_____ ; while reading a book _____; while a passenger in a car _____; while in a traffic jam _____.
    - Fall asleep involuntarily during the day, even when doing something important or stimulating?……..YES NO
      If YES, check each example that applies to you: While driving _____; while doing your work_____; while talking to others_____.
    - Have trouble functioning during the day?…….. YES NO

12. Do your ever sleep 9 or more hours and still wake up unrefreshed?…….....YES NO

13. Do you snore?……YES NO
    If YES: How loudly?…… SOFTLY _____ MODERATELY ____ LOUDLY ____ VERY LOUDLY _____
    Do you wake others with your snoring?……...YES NO
    How many nights per month?……._____

14. Do you gasp or snort when you sleep?……...YES NO

15. Do you moan when you sleep?……...YES NO

16. Have you ever awakened with a choking or smothering sensation?…… ……YES NO
    If YES: How often? ……..._____

17. Do you awaken in the mornings with a headache?……YES NO
    If YES: How often? ……._____

18. Does it often take you longer to fall asleep because your legs feel restless or odd in bed?…….……YES NO
    If YES: Does moving your legs in bed, or getting up and moving around help you fall asleep?…..……YES NO
    How many nights per month do your legs feel this way?……...YES NO

19. Do you often wake up from a sound sleep repeatedly because your legs jerk?…….……YES NO
    If YES: Are your leg movements frequent and regular?……...YES NO
    How many nights per month does this happen?……..._____

20. Do you have sleep attacks in which you suddenly and uncontrollably fall asleep?…….....YES NO
    If YES: How many minutes do you sleep (nap) when you have such an attack?…… ..._____
    Do you awaken from your nap feeling refreshed?……..YES NO
    How many times per month does this happen?……..._____

21. When you are startled, emotional, excited, or happy do you often experience extreme weakness (for example,

in your legs) or drop things?……YES NO

22. When you are startled, emotional, excited or happy do you <u>often</u> collapse or fall?……YES NO
    If YES: Are you still aware of your surroundings?……YES NO

23. As you fall asleep or wake up, do you <u>often</u> see things that are not there?……YES NO
    If YES: Are the things you see very clear and realistic?……YES NO
    How many times each <u>month</u> does this happen?…….._____

24. As you fall asleep or wake up, do you <u>often</u> feel unable to move (paralyzed)?……YES NO
    If YES: How many times each <u>month</u>?……....._____

25. How many nights have nightmares awakened you in the last <u>month?</u>……....._____
    If ANY: How intense are they? (1=Mild, 2= Frightening, 3=Terrifying)……....._____

26. Do you often move violently during your sleep while dreaming, and sometimes even hurt yourself or your partner by accident or fall out of bed?……YES NO

27. Do you often wake up from a deep sleep sweating, your heart beating fast or pounding, with a feeling of fear but with <u>no memory of a dream</u>?……..YES NO
    If YES: How many times in the last <u>month</u> has this happened?……....._____
    How intense is this experience? (1=Mild, 2=Frightening, 3=Terrifying)……....._____
    Does this ever happen during the day?……YES NO

28. Do you <u>often</u> grind your teeth in your sleep?……YES NO

29. How many <u>times each night</u> do you wake up specifically to use the bathroom?……...._____

30. How many <u>nights each week</u> do you wake up with indigestion or heartburn?……..._____

31. Do you <u>often</u> eat your last meal or a large snack within 2 hours of bedtime?……YES NO

32. Do you wake up during the night to eat?…… ……YES NO

33. Do you <u>often</u> exercise vigorously within an hour of bedtime?……...YES NO

34. How many nights each <u>month</u> do you use alcohol within 2 hours of bedtime?……_____

35. How many nights each <u>month</u> do you use alcohol to help you fall asleep?……...._____

36. How many caffeinated beverages do you drink in a <u>day</u>?……....._____

37. How many <u>days</u> a week do you drink caffeinated beverages after 7 p.m.?……....._____

38. Do you smoke?……...YES NO
    If YES: How many cigarettes per day?……..._____
    If YES: Do you wake up at night to smoke?……..YES NO

39. Have you ever smoked?……..YES NO
    If YES: How long ago?……....._____

40. How often is your sleep problem caused or made worse by physical discomfort or pain? (check one):
    Never_____ Rarely____ Sometimes_____ Often_____ Most or All of the Time____

41. Do you <u>ever</u> work night shifts (any 8-12 hour shift starting after 6 pm)?……YES NO

If YES: How many nights per month?……....._____

42. Do you often work at home after 8 pm?……YES NO
    If YES: How many nights per week?……....._____

43. Do you deliberately sleep less in order to do other things?……YES NO
    If YES: How many nights per week?……....._____
    How many hours per night?……....._____

44. On weekends or your days off, do you often sleep more than 1 hour later than your usual wake up time?
    ……YES NO

45. Do you often go to bed earlier to make up for lost or unrefreshing sleep?……YES NO

46. Do you often wake up later to make up for lost or unrefreshing sleep?……YES NO

47. Do you take naps?……...YES NO
    If YES: How many times each week do you take naps?……....._____
    How many minutes are your naps, on average?……....._____
    Do you awaken from your naps refreshed?…….....YES NO
    Do you have dreams during your naps?……YES NO

48. Do you often lose sleep because your bed partner disturbs you at night?…….....YES NO

49. Is your sleep often disturbed by environmental factors, such as traffic, neighbors of family members? …….YES NO

50. Do you often lose sleep because your bedroom is not dark enough at night?……YES NO

51. Do you often lose sleep because your bedroom temperature is not comfortable enough at night?……YES NO

52. Do you usually sleep better when you sleep away from home?……YES NO

53. When you try to sleep, does worrying or problem solving often keep you awake?……...YES NO

54. Do you often worry, in bed, about getting enough sleep to function the next day?……...YES NO

55. Do you often get frustrated and angry, in bed, about not getting to sleep?……YES NO

56. Do you worry too much in general?……...YES NO

57. When you try to go to sleep does your mind race with many thoughts? ……YES NO

58. Have you been under noteworthy stress recently?……..YES NO

59. Check if you are currently diagnosed with: _____depression _____an anxiety disorder

60. Have you recently taken any prescription or over-the-counter medication for sleep problems?……...YES NO
    If YES: How many nights a week do you usually take this medication?……..._____
    How many months have you been taking this medication?……_____

61. Do you take any medications that contain caffeine or other stimulants, such as allergy medications, nasal decongestants, or pain killers?……YES NO
    If YES: How many minutes or hours before trying to sleep do you take them?……_____

62. Please list all prescription and over-the-counter medications you are now taking, and what each is for:

MEDICATION	CONDITION	MEDICATION	CONDITION

63. Please list any medications you have recently stopped taking, and what each was for:

MEDICATION	CONDITION	MEDICATION	CONDITION

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Print out this test, fill in your answers and see where you stand.

Situation	Chance of Dozing or Sleeping
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up) (This is your Epworth score)	____

You may write any additional information that you think could be helpful in the space below: