

**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 you 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 often 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 often 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 month does this happen?.....
24. As you fall asleep or wake up, do you often feel unable to move (paralyzed)?.....YES NO  
 If YES: How many times each month?.....
25. How many nights have nightmares awakened you in the last month?.....  
 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 no memory of a dream?.....YES NO  
 If YES: How many times in the last month 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 often grind your teeth in your sleep?.....YES NO
29. How many times each night do you wake up specifically to use the bathroom?.....
30. How many nights each week do you wake up with indigestion or heartburn?.....
31. Do you often 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 often exercise vigorously within an hour of bedtime?.....YES NO
34. How many nights each month do you use alcohol within 2 hours of bedtime?.....
35. How many nights each month do you use alcohol to help you fall asleep?.....
36. How many caffeinated beverages do you drink in a day?.....
37. How many days 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 ever 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	_____
<b>Total score (add the scores up)</b>	_____
(This is your Epworth score)	_____

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