SLEEP QUESTIONNAIRE AND WAKEFULNESS

(SQAW)

PATIENT: _____

DOCTOR: _____

DATE COMPLETED: _____

Must Be Completed by Appointment Date

7423-029-W-BKLT 11-1-09

For questions to be answered on a scale of 1 to 5, please circle your best answer where ***1 = NEVER*** *and* ***5 = ALWAYS****.*

GENERAL

DO YOU FEEL THAT YOU:

1.	get too little sleep at night?			Yes		No
2.	get too much sleep at night?			Yes		No

HOW GREAT A PROBLEM DO YOU HAVE:

3.	with getting to sleep at night?	1	2	3	4	5
4.	with waking up during the night?	1	2	3	4	5
5.	with waking up/getting up in the morning?	1	2	3	4	5
6.	with non-restorative sleep (that is, no matter how much sleep you get, you don't wake up feeling rested)?	1	2	3	4	5
7.	with SLEEPINESS (feeling sleepy or struggling to stay awake) in the daytime?	1	2	3	4	5
8.	with FATIGUE (tiredness, exhaustion, lethargy) even when you are NOT sleepy?	1	2	3	4	5

WORK WEEK SLEEP

9.	Do you have difficulty falling asleep?	1	2	3	4	5
10.	What time do you usually go to bed on WEEKDAYS?	_____ am			_____ pm	
11.	How long after going to bed do you usually turn off the lights and decide to go to sleep?	_____ hr			_____ min	
12.	How long does it usually take you to fall asleep?	_____ hr			_____ min	
13.	What time do you get up in the morning?	_____ am/pm				

WEEKEND SLEEP

14.	What time do you usually go to bed?	_____ am/pm
15.	What time do you get up in the morning?	_____ am/pm

DURING THE NIGHT (that period of an average day during which you normally sleep)

16. What is the total number of hours of sleep you usually get at night (DO NOT include time that you spend awake in bed at night)? _____ hr _____ min

17. How many times do you wake up during a typical night's sleep? _____ times

18. How long is the typical longest wake time? _____ hr _____ min

19. When you awake in the middle of the night, How long does it take you to get back to sleep? _____ hr _____ min

SLEEP DISRUPTION

20. How often do you usually get up during the night to urinate?	1	2	3	4	5
21. How often do you get out of bed during a typical nights sleep?	1	2	3	4	5
22. How often do you fear not being able to go to sleep once you have awakened during the night?	1	2	3	4	5
23. How often do you go to sleep with a TV/radio on?	1	2	3	4	5
24. How often do sleep with a TV/radio on?	1	2	3	4	5

WHEN FALLING ASLEEP AT THE BEGINNING OF THE NIGHT, HOW OFTEN DO YOU?

25. feel afraid of not being able to get to sleep?	1	2	3	4	5
26. feel unable to move (paralyzed)?	1	2	3	4	5
27. notice that parts of your body startle or jerk?	1	2	3	4	5
28. experience restless legs (crawling or aching feelings and inability to keep legs still)?	1	2	3	4	5
29. experience vivid, dream-like scenes (hallucinations) even though you know that you are awake?	1	2	3	4	5
30. experience any kind of pain or physical discomfort?	1	2	3	4	5

WHAT POSITION DO YOU SLEEP?

Back	1	2	3	4	5
Side	1	2	3	4	5
Stomach	1	2	3	4	5

HOW OFTEN DO YOU:

31.	have nasal congestion (stuffiness, nasal obstruction) during the night?	1	2	3	4	5
32.	use tablets, nasal spray or other medications in order to deal with nighttime nasal congestion?	1	2	3	4	5
33.	snore in any way?	1	2	3	4	5
34.	snore loudly and disruptively?	1	2	3	4	5
35.	hold your breath or stop breathing during sleep?	1	2	3	4	5
36.	suddenly wake up gasping for air or unable to breathe?	1	2	3	4	5
37.	awake panicking or anxious during the night?	1	2	3	4	5
38.	notice that your heart pounds (beats strongly), beats rapidly, or beats irregularly (palpitations) during the night?	1	2	3	4	5
39.	wake up with chest pains?	1	2	3	4	5
40.	sweat excessively during the night?	1	2	3	4	5
41.	dream at night?	1	2	3	4	5

HOW OFTEN IS YOUR SLEEP DISTURBED BECAUSE OF:

42.	a persistent cough?	1	2	3	4	5
43.	inability to breathe in a flat position due to shortness of breath?	1	2	3	4	5
44.	“gas” in your stomach, indigestion, dyspepsia or heartburn?	1	2	3	4	5
45.	regurgitation (or burning in the throat, choking or gagging on stomach contents?)	1	2	3	4	5

HOW OFTEN DO YOU:

46.	walk in your sleep?	1	2	3	4	5
47.	talk in your sleep?	1	2	3	4	5
48.	grind your teeth during your sleep?	1	2	3	4	5
49.	wet your bed as an adult?	1	2	3	4	5

HOW OFTEN DO YOU:

50.	have your sleep disturbed during the night by headaches?	1	2	3	4	5
51.	depend on an alarm clock (or other artificial means) to wake up?	1	2	3	4	5
52.	notice unusual difficulty waking up in the morning?	1	2	3	4	5
53.	wake up extremely disoriented, confused or even violent?	1	2	3	4	5
54.	wake up with a morning headache?	1	2	3	4	5
55.	feel unable to move (paralyzed) when waking up?	1	2	3	4	5
56.	have dream-like images (hallucinations) when waking even though you know you are not asleep?	1	2	3	4	5
57.	wake up with a dry mouth/throat?	1	2	3	4	5
58.	awaken well rested?	1	2	3	4	5
59.	If not rested, does increased sleep help?	1	2	3	4	5

OTHER DAYTIME BEHAVIOR

HOW OFTEN DO YOU:

60.	discover that you have performed a complex act such as driving a car to the wrong destination and can't remember how you did it?	1	2	3	4	5
61.	find yourself doing things that make no sense (such as writing nonsense or mixing chocolate and gravy)?	1	2	3	4	5
62.	get told that you were acting strangely without you being aware of it at the time?	1	2	3	4	5
63.	have a feeling of "weak knees" when you laugh?	1	2	3	4	5
64.	have a feeling of sudden muscular weakness (paralysis or inability to move) when laughing, angry, or in other emotional situations?	1	2	3	4	5
65.	think you are excessively sleepy during the daytime?	1	2	3	4	5

QUESTIONS ABOUT YOUR GENERAL HEALTH

WHAT IS (OR WAS) YOUR BODY WEIGHT?

66.	Now	6 mos ago	2 yrs ago	At age 20	Heaviest
	_____ lbs	_____ lbs	_____ lbs	_____ lbs	_____ lbs

HOW OFTEN DO YOU:

67.	have swelling in your ankles?	1	2	3	4	5
68.	suffer from uncomfortable feelings (numbness, "pins and needles") in your arms/legs (paresthesia)?	1	2	3	4	5
69.	have headaches during the day?	1	2	3	4	5
70.	suffer from dizzy spells?	1	2	3	4	5
71.	have episodes of loss of consciousness or fainting?	1	2	3	4	5
72.	have seizures or epilepsy?	1	2	3	4	5
73.	have muscular weakness in any part of your body?	1	2	3	4	5
74.	have shortness of breath?	1	2	3	4	5
75.	have heart flutters (irregular heart rhythm, palpitations) or rapid heart rate?	1	2	3	4	5
76.	chest pain?	1	2	3	4	5

FOR WOMEN

77.	Are you post menopause (change of life)?	Yes	No
78.	Are you having menopausal symptoms at present?	Yes	No

EMOTIONAL AND SOCIAL ASSESSMENT

LIFE DISSATISFACTIONS

79.	How often have you considered or attempted suicide?	_____ Times	
80.	Are you dissatisfied or do you have a problem with any other areas not mentioned?	Yes	No
81.	Have you ever seen a clinical psychologist/psychiatrist?	Yes	No
82.	Have you ever been admitted to a hospital for psychiatric reasons?	Yes	No

83. My memory is not as sharp as it used to be? Yes No

84. Lately I find myself losing my temper? Yes No

85. Previous sleep testing:

Month	Year	Location	Reason for Admission

(Please obtain a copy of previous sleep studies to bring with you.)

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES:

86.	within two hours of trying to go to sleep?	1	2	3	4	5
87.	during the night?	1	2	3	4	5
88.	Do you consume significantly LESS alcohol now than you did in the past?			Yes		No

HOW OFTEN HAVE YOU:

89.	used alcohol in order to get to sleep?	1	2	3	4	5
90.	used alcoholic beverages within a few hours of awakening (e.g., a morning drink)?	1	2	3	4	5
91.	gotten sick from drinking alcoholic beverages?	1	2	3	4	5
92.	had blackouts associated with alcoholic beverages?	1	2	3	4	5

HOW OFTEN HAVE YOU USED:

93.	marijuana (or THC)?	1	2	3	4	5
94.	cocaine?	1	2	3	4	5
95.	hallucinogenic drugs (LSD, mescaline, angel dust [PCP] peyote)?	1	2	3	4	5
96.	stimulants (uppers)?	1	2	3	4	5

HOW OFTEN HAVE YOU USED:

97.	depressants (downers)?	1	2	3	4	5

98. narcotics (heroin, morphine, opium)? 1 2 3 4 5

99. other (e.g., glue sniffing, etc.)? 1 2 3 4 5

MEDICINES

HAVE YOU EVER TAKEN MEDICINE TO HELP YOU WITH:

100. getting to sleep? Yes No

If so, what? _____

101. a problem with daytime sleepiness (staying awake and alert) or fatigue? Yes No

If so, what? _____

EXERCISE

102. How many times in a usual week do you participate in a sport or partake in some other form of physical exercise? _____ times

For how long? _____

103. How many hours per week do you work? _____ hours

From _____ am/pm To _____ am/pm

104. What is (or was) your spouse's occupation? _____

PRESENT LIVING SITUATION

105. How many times have you been married? _____ times

106. What was your age at the time of your first marriage? _____ years

107. What is the longest period of time that you have lived with your present spouse or living companion? _____ years _____ months

108. How well do you and your spouse or living companion get along? 1 2 3 4 5

CONCLUSION

109. Now that you have completed this questionnaire, do you feel that your sleep OR daytime alertness is abnormal in any way? Yes No

110. What is your personal interpretation as to why you have your particular sleep/wake problem?

_____

_____

_____

_____

_____

_____

IS THERE ANYTHING ELSE?

111. If your sleep/wake behavior is not adequately covered by the previous questions, please describe the nature of your sleep/wake behavior and list anything else (not yet covered) which especially interferes with your sleep or wakefulness:

_____

_____

_____

_____

_____

_____

PLEASE CHECK THROUGH THE QUESTIONNAIRE TO SEE IF YOU HAVE ANSWERED ALL QUESTIONS. ***THANK YOU!***