WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF PULMONARY AND SLEEP MEDICINE
SLEEP QUESTIONNAIRE

Patient Name: _____

Date of Birth/Age: _____

Please list any medications you have tried for improving sleep or staying awake:

Drug and Dose	Frequency	Date Started

In General Terms please describe your Sleep problems

_____
_____
_____
_____
_____
_____

Does your job require shift work? (   ) YES   (   ) NO

My normal workings hours are: _____

Doctor's Notes (DO NOT WRITE IN SPACE BELOW)

Please (X) the column you feel most accurately describes the following Situations:

	ALWAYS	OFTEN	SOMETIMES	NEVER

I wake up gasping, wheezing, short of breath or feeling like I can't breathe.	
I have been told that I toss and turn a lot in my sleep.	
I wake up with stomach acid in my mouth.	
I am troubled by sensations in my legs (restlessness, etc...)	
I fall asleep unexpectedly for short periods of time while sedentary (i.e. at meetings, watching Television, at the movies, or while riding in the car.	
I fight sleep while driving.	

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of like in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you. Use the following scale to choose *the **most appropriate number*** for each situation.

0- Would ***never*** doze   **1**- ***Slight*** chance of dozing
2- ***Moderate*** chance of dozing   **3**- ***High*** chance of dozing

Situation	**Chance of Dozing**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (i.e. Theater or in a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances Permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while being stopped in traffic for a few minutes	0	1	2	3

TOTAL/OUT of 24_____