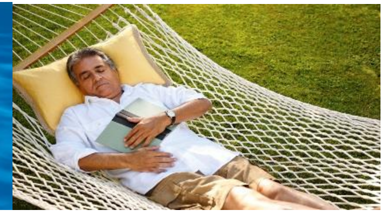
Kaiser Permanente Vacaville Sleep Clinic
Sleep Questionnaire



Name:________________________ Kaiser #:______________ Date:________

Sleep Habits

Average bedtime:________________________

Number of awakenings at night: ______________ Primary reason for awakening:________________

Estimated total sleep time: ________________

Do you smoke? ❐ Yes ❐ No Do you use alcohol on a regular basis? ❐ Yes ❐ No If yes, how much?__________

Nighttime Symptoms (Please check all that apply)

❐ Snoring ❐ Pauses in breathing ❐ Mouth breather ❐ Heartburn
❐ Drink water ❐ Awake to urinate ❐ Grind teeth ❐ Bed-wetting
❐ Acting out dreams ❐ Nightmares ❐ Night terrors ❐ Sleepwalking or sleep talking
❐ Become sweaty or prefer the room cool ❐ Hallucinations as you fall asleep or awaken
❐ Bed partner complains your legs jerk at night

Daytime Symptoms (Please check all that apply)

❐ Awaken feeling unrefreshed ❐ Awaken with headaches ❐ Awaken with dry mouth
❐ Fatigue ❐ Sleepiness ❐ Take naps
❐ Impotence ❐ Inability to concentrate ❐ Hyperactivity
❐ Driving difficulties: Near misses or accidents due to sleepiness.
❐ Consume caffeinated products (e.g. coffee, tea, soda or chocolate) to stay awake.
❐ Experience weakness if you laugh or become angry.

Please describe your sleep problem

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Epworth Sleepiness Scale.

How likely are you to accidently doze off in the following situations?

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	0	1	2	3
Sitting and reading	❐	❐	❐	❐
Watching Television	❐	❐	❐	❐
Sitting Inactive	❐	❐	❐	❐
As a passenger in a car for an hour without a break	❐	❐	❐	❐
Lying down to rest in the afternoon	❐	❐	❐	❐
Sitting and talking to someone	❐	❐	❐	❐
Sitting quietly after lunch (when you've had no alcohol)	❐	❐	❐	❐
In a car, while stopped at traffic	❐	❐	❐	❐

Total Score:__________

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