

Name: _____

Date: _____

ANSM SLEEP PROGRAM QUESTIONNAIRE

Some questions might be better answered by your spouse, bed-partner, parent, or roommate.

1. How long does it usually take you to fall asleep after deciding to go to sleep? _____
2. What is the total number of hours of sleep that you usually get at night? _____
3. How many times do you wake up during a typical night's sleep? _____
4. How long do you spend awake during the night? _____
5. How many naps do you take on purpose in a usual week? _____
6. If you are having problems with sleepiness, at what age did you first notice this? _____
7. How many times have you had motor vehicle accidents caused by sleepiness? _____
8. How many times have you had near motor vehicle accidents caused by sleepiness? _____

	Yes	No
9. Do you have difficulty getting to sleep at night?		
10. Do you have difficulty staying asleep at night?		
11. Do you work nights?		
12. Do you work rotating shifts?		
13. Do you have restless or disturbed sleep?		
14. Do you feel unrefreshed when you wake up in the morning?		
15. Do you typically feel sleepy (struggling to stay awake) or fatigued during the day?		
16. Does sleepiness cause a problem at school or at work?		
17. Do you have vivid dream-like images or hallucinations as you are falling asleep?		
18. Do you have vivid dream-like images or hallucinations as you are waking up?		
19. Do you feel paralyzed (unable to move) as you are falling asleep?		
20. Do you feel paralyzed (unable to move) as you are waking up?		
21. Do you have a feeling of "weak knees" when you laugh?		
22. Do you have episodes of sudden weakness or inability to move) in emotional or exciting situations?		
23. Do you snore in any way? If yes, do you snore loudly?		
24. Do you hold your breath or stop breathing during sleep?		
25. Do you have frequent dry mouth or sore throat when you awaken?		
26. Do you wake yourself up with loud snores or snorts?		
27. Do you gasp for air when you are asleep?		
28. Do you feel that you are under a great deal of stress?		
29. Do you drink something alcoholic to help you sleep?		
30. Do you worry about things at bedtime?		
31. Do you remain in bed even when you can't go to sleep?		
32. Do you have an urge to move your legs, usually accompanied or caused by uncomfortable and unpleasant sensations in your legs?		
33. Do you have the urge to move or unpleasant sensations begin or worsen during periods of rest or inactivity such as lying or sitting?		
34. Do you have the urge to move or unpleasant sensations which are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues?		
35. Do you have the urge to move or unpleasant sensations which are worse in the evening or night than during the day or only occur in the evening or night?		
36. Do you have leg cramps (Charlie horses) at night?		
37. Do you walk in your sleep?		
38. Do you "act out" your dreams?		
39. Do you have twitching or kicking of your legs during sleep?		
40. Do you have nightmares?		
41. Do you have numbness or tingling in the hands?		
42. Do you have numbness or tingling in the feet?		