Insomnia Questionnaire

1.) Sleep Schedule

a. Usual bedtime:____________________ Does bedtime vary? ☐ Yes ☐ No

b. Usual wake up time:________________

c. How many hours of sleep do you average per night:____________________

d. What do you do when you can't fall asleep? (Select all that apply)

☐ Stay in Bed ☐ Watch TV ☐ Use electronics ☐ Work ☐ Other activities_____________________________

2.) Do you take naps during the day? ☐ Yes ☐ No

3.) Do you have difficulty staying asleep? ☐ Yes ☐ No If yes, what do you do? (Select all that apply)
☐ Stay in Bed ☐ Watch TV ☐ Use electronics ☐ Work ☐ Other activities_____________________________

4.) Do you do any other activities in bed besides sleep or intimacy? ☐ Yes ☐ No

5.) Any environmental issues that affect your sleep (Please check)
☐ Temperature ☐ Bed is uncomfortable ☐ Light exposure ☐ Noise ☐ Other______________________________

6.) Do you take any medications to help you sleep?
☐ Yes - ☐ Ambien ☐ Melatonin ☐ Other____
☐ No

7.) Do you drink alcohol at night? ☐ Never ☐ Rarely (1-2 drinks/wk) ☐ Moderate (3-10 drinks/wk)

8.) Do you have a medical condition that disrupts your sleep? ☐ Yes ____
☐ No

Besides Tylenol or ibuprofen, are you taking any pain medications? ☐ Yes__________________________________
☐ No

9.) Any history of depression? ☐ Yes If yes, any medications for tx ____
☐ No

10.) Please check all the following that apply regarding your sleep in the past week

When awakened during the night, I have difficulty going back to sleep ☐ Yes ☐ No ☐ Sometimes

When trying to fall asleep, I am worried about whether sleep will occur ☐ Yes ☐ No ☐ Sometimes

When trying to go to sleep, mind races with many thoughts ☐ Yes ☐ No ☐ Sometimes

Pain often causes arousals or prevents me from going back to sleep ☐ Yes ☐ No ☐ Sometimes

11.) Do you snore at night? ☐ Yes ☐ No ☐ Not sure

12.) Has anyone said you stop breathing or choke in your sleep? ☐ Yes ☐ No

13.) Do you have difficulty staying awake during the day? ☐ Yes ☐ No

Epworth Sleepiness Scale

Use this scale to determine your patient's level of sleepiness.

Choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a motor vehicle for an hour or more	
Lying down to rest in the afternoon when circumstances permits	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score (add the scores up) (This is your Epworth score)	

If your patient scores 10 or more, we recommend your patient consult one of our physicians to treat a sleep disorder, address an underlying condition affecting sleep and develop proper sleep hygiene.