Sleep Questionnaire (Screen)

You will be completing 2 sleep questionnaires. Questions will be repeated on both questionnaires but please answer them as best as you can.
Thank you for your time and effort!

Dr Tony Fernando (Department of Psychological Medicine, University of Auckland)

Name: _____ DOB_____
Name of GP_____

a. Do you have trouble with your sleeping (on at least 3 nights per week) such that it interferes with your activities the following day (eg unrefreshed in the morning, fatigued, poor concentration or irritability).

☐ No ☐ Yes

Ai. If you sleep well is this with the help of sleep medication?

☐ No go to **question b.** ☐ Yes

Aii. If you do use medication what is the name of this medication? _____

b. If you have problems with sleep then answer the following questions,
if you don't have sleep problems skip to page 3 -main sleep questionnaire. Page 3.

c. Are you a shift worker?

☐ No ☐ Yes Office only ☛ consider referral

c. i. How long have you had this sleep problem?_____

ii. If ***yes*** has something happened to you to cause this problem? When did it happen (please write)

.....

.....

Please answer the following questions

d. During the past month have you often been bothered by feeling down depressed or hopeless?

☐ No ☐ Yes

e. During the past month have you often been bothered by having little interest or pleasure in doing things

☐ No ☐ Yes

If you answered yes to either *d* or *e,* **is this something with which you would like help**

☐ No
☐ Yes but not today
☐ Yes

Sleep Questionnaire (Screen)

f. During the past month have you been worrying a lot about every day problems?

☐ No ☐ Yes ☛ **is this something with which you would like help**

- ☐ No
- ☐ Yes but not today
- ☐ Yes

g. Do you snore very loudly at night

☐ No ☐ Yes

Do you find yourself falling asleep during the day i.e in waiting rooms or as a passenger in a vehicle?

☐ No ☐ Yes

h. When you can choose do you go to bed late at night i.e after midnight

☐ No ☐ Yes

When you can choose (i.e weekends) do you sleep late in to the morning i,e after 10 am

☐ No ☐ Yes

i. Do you do anything unusual when you are asleep i.e sleep walking/talking or restless legs or grinding your teeth?

☐ No ☐ Yes

j. Do you have any significant health problems such as pain or breathing difficulty or acid reflux or night cough that affects your ability to sleep well?

☐ No ☐ Yes

k. Do you ever feel the need to cut down on your drinking alcohol?
(tick no if you do not drink alcohol OR do not feel the need to cut down)

☐ No ☐ Yes

L. In the last year, have you ever drunk more alcohol than you meant to

☐ No ☐ Yes ☛ **is this something with which you would like help**

- ☐ No
- ☐ Yes but not today
- ☐ Yes

M. Do you ever feel the need to cut down on your non-prescription or recreational drug use?
(tick no if you do not use other drugs OR do not feel the need to cut down)

☐ No ☐ Yes

N. In the last year, have you ever used non prescription or recreational drugs more than you meant to?

☐ No ☐ Yes

If you answered yes to either *M* or *N,* ***Is this something with which you would like help?***

☐ No ☐ Yes ☛ **is this something with which you would like help**

- ☐ No
- ☐ Yes but not today
- ☐ Yes

Sleep Questionnaire (Screen)

Main Sleep Questionnaire

Some of the questions here are repeats of previous questions. We would be grateful if you could do the repeat questions as this helps us with the evaluation of the questions. –thank you

Please tick appropriate box:

(a) Gender: ☐ Male ☐ Female

(b) Age in years: _____

(c) What ethnic group do you belong to? ***(Tick appropriate box)***

☐ NZ European ☐ Maori ☐ Cook Island Maori ☐ Samoan ☐ Tongan

☐ Indian ☐ Other (such as Dutch, Japanese, Tokelauan).

Please state which applies .....

(d) What is your present marital status? ☐ Single ☐Married ☐ De facto

(e) What is your home phone number? .....

(f) What is your mobile number? .....

(g) What is your work number? .....

(h) Which is the best time to contact you? .....

(i) What is your email address? .....

1. During the past month, how would you rate your sleep quality overall?

i. Very good ☐

ii. Fairly good ☐

iii. Fairly bad ☐

iv. Very bad ☐

Please answer the following:

1a. Do you have problems getting to sleep, staying asleep or waking early such that it affects your work function the next day- this includes feeling excessively sleepy the next day?

☐ No ☐ Yes

If ***no***, go to Q4. If yes please proceed to **1b**

1b. If ***yes,*** to the above, how long has this been going on (please write). .....

1c. If ***yes,*** was there some event that caused this? (please describe).

.....

.....

.....

……

1d. If you are currently working please answer this question.

i. In the past year, did you miss work because of poor sleep? ☐ No ☐ Yes

ii. If yes, approximately how many days work did you miss? …….. days.

iii. Were there specific reasons for your poor sleep? i.e. baby crying, sick family member, partying too late, work/school requirements?

……

2. If you are having problems with your sleep have you discussed this with a doctor?

☐ No ☐ Yes

If ***No,*** is there a reason for this (please tick one box).

i. The sleep problem started since last visit to GP ☐
ii. Did not think it was important enough ☐
iii. Did not think anything could be done for it ☐
iv. Concerned I may be given medication for it ☐

Other reason please write ……

3. If you do have a problem with sleeping and you have not discussed it with a doctor do you plan to do this today?

i. ☐ No ☐ Yes If ***no*** go to Q4.

ii. If ***yes*** was this one of the reasons for you seeing your doctor today? ☐ No ☐ Yes

Sleep Questionnaire (Screen)

4. Over the last 2 weeks, how often have you been bothered by any of the following problems? ***Please circle the number that applies to you including not at all where that is the case***

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things?	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

5. Over the last 2 weeks, how often have you been bothered by any of the following problems? ***Please circle the number that applies to you including not at all where that is the case.***

		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Having trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

6. Are you a shift worker? ☐ No ☐ Yes If ***no*** go to Q7.

i. If ***yes*** choose one of the answers below:

- Do you work the same shift? eg nights ☐ No ☐ Yes
- Do you do rotating shifts? ☐ No ☐ Yes

ii. If ***yes*** do you have problems with your sleep that may be caused by being a shift worker? ☐ No ☐ Yes

7. Do you have any health problems that affect your ability to sleep well (such as pain, breathing difficulty or acid reflux or night cough)? ☐ No ☐ Yes

Please describe: ……..

……

Sleep Questionnaire (Screen)

Regarding the use of alcohol:

8i. Have you ever felt you should cut down on your drinking? ☐ No ☐ Yes

8ii. Have people annoyed you by criticizing your drinking? ☐ No ☐ Yes

8iii. Have you ever felt bad or guilty about your drinking? ☐ No ☐ Yes

8iv. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of your hangover? ☐ No ☐ Yes

9. Women only ***(men go to Q10a)***

i. Are you postmenopausal?

☐ No ☐ Yes

ii. If ***yes*** do you experience hot flushes?

☐ No ☐ Yes. If ***no,*** go to Q10

iii. If ***yes,*** how many times per night do you awaken due to hot flushes? .....

iv. If ***yes,*** do these significantly affect your sleep? ☐ No ☐ Yes

v. If ***yes,*** how many nights per week do you experience insomnia due to the hot flushes? .....

Both men and women continue from here

10a. Do you experience excessive sleepiness during the day? (e.g. falling asleep in waiting rooms, lectures or when a passenger in a car?)

☐ No ☐ Yes

10b. Do you experience frequent episodes of breathing pauses (or gasping for air) during sleep. Or "has someone told you that you stop breathing while you are asleep?"

☐ No ☐ Yes

If you answered ***no*** to 10a or 10b please go to question 11a (below).

10c. Do you:

i. Snore very loudly - ☐ No ☐ Yes

ii. Get morning headaches - ☐ No ☐ Yes

iii. Have a dry mouth upon awakening? - ☐ No ☐ Yes

11a. At night, do you get unpleasant sensations in your legs (aches, pains, creeping sensations) which affect your sleep?

☐ No ☐ Yes

11b. If ***yes***, are these sensations relieved by movement, rubbing or walking?

☐ No ☐ Yes

Sleep Questionnaire (Screen)

12a. Do you consider yourself naturally a (tick one):

☐ Morning person or a "lark" (someone who normally wakes up early and feels sleepy before 11.00 pm?)
☐ Evening person or an "owl" (someone who normally can stay up late, around midnight or later, and prefer to sleep in late in the morning?)
☐ Neither type ***or*** in between
☐ Unsure

12b. When you can choose, (e.g weekends or holidays) do you go to bed late at night e.g. after midnight?

☐ No ☐ Yes

12c. When you can choose do you sleep in late in the morning e.g. after 10.00 am?

☐ No ☐ Yes

12d What time do you usually go to bed _____

12e What time do you usually get up _____

12f How many hours do you actually sleep _____(this can be different from the hours you spend in bed

13a. Do you sleep walk? If no go to **14a** ☐ No ☐ Yes

13b. Did this start before you were a teenager? ☐ No ☐ Yes

i. When you are walking in your sleep is it difficult for others to wake you up? ☐ No ☐ Yes

ii. Do you have trouble remembering the episode(s) of sleep walking? ☐ No ☐ Yes

iii. Do these sleep walking episodes occur during the first third of your time asleep? ☐ No ☐ Yes

14a. Do you talk or speak when you are asleep (others may say you do if so answer yes)

☐ No ☐ Yes

If no go to **Q15** otherwise **Q14b**.

14b. I sleep talk : (tick one)

☐Less than once per week?
☐More than once per week, but less than nightly and they cause mild disturbance to my bed partner (if you have one)?
☐I have had these symptoms nightly and they cause pronounced interruption to my bed partner's sleep (if you have one)?

14c. Do you remember talking in your sleep when you awaken?

☐ No ☐ Yes

Sleep Questionnaire (Screen)

15a. Do you grind your teeth or clench your teeth when asleep? ☐ No ☐ Yes

If ***no*** go to Q16.

15b. Do you have:

i. Abnormal wear of your teeth? ☐ No ☐ Yes
ii. Sounds associated with teeth grinding? ☐ No ☐ Yes
iii. Jaw muscle discomfort? ☐ No ☐ Yes

16. Do you have recurrent severe nightmares that wake you up? ☐ No ☐ Yes
If yes how often does this happen _____

17. Do you wake up in the middle of the night having an anxiety or panic attack? (palpitations, pounding Heart, difficulty breathing, shaking, feeling faint?)

☐ No ☐ Yes

If yes how often does this happen _____

18. Have you ever taken any of the following drugs to get high, to feel better or to change your mood over the past 3 months? ☐ No ☐ Yes

If **no**, you have completed the questionnaire.

If **yes**, circle the one(s) you have used and write how often you use them i.e. daily, weekly, monthly

Name of drug		How often
Cannabis (marijuana, dope, grass, pot, weed, reefer, Hashish (hash), THC etc)	No/yes	
Stimulants (amphetamines, ritalin, speed, "P", diet pills, "ice")	No/ yes	
Cocaine, crack, snorting, speedball	No/ yes	
Heroin, Morphine, Opium, Codeine, Methadone, DHC, Oxycontin	No/yes	
LSD, Ecstasy, PCP, Angel Dust, Fantasy, Datura, Mushrooms	No/yes	
Inhalants, Solvents (glue, petrol, amyl or butyl nitrate, "poppers", nitrous oxide, laughing gas)	No/yes	
Other prescription medicines to get you high	No/yes	

19. Do you think the use of drugs is affecting your sleep either when you are taking them or after you stop taking them?

☐ No ☐ Yes

20. Do you think the use of these drugs affect your quality of sleep (while you are using them or after you stop taking them?

☐ No ☐ Yes

----------end----------