SLEEP QUALITY SELF-ASSESSMENT

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NAME _____ **DATE** _____
AGE _____ **GENDER** ____◯ **Male** ____◯ **Female**

DIRECTIONS:
This assessment is for individuals who notice consistent sleep disturbances, or have reports of a spouse or partner noticing their sleep disturbances. Please answer all the questions that follow. It may be helpful to ask those who witness your sleep habits for their feedback so the answers are as complete as possible.

Please list a score next to each question listed below. Please use the following guidelines to determine your score:
1 = never, none, not at all, not applicable
2 = rarely (e.g. frequency of 1 to 2 times per year) **OR** slight intensity
3 = sometimes, occasionally (e.g. frequency up to 1 to 2 times per month) **OR** mild intensity
4 = usually, quite often (e.g. frequency up to 2 to 4 times per week) **OR** moderate intensitiy
5 = always or almost always (from 5 times per week up to virtually daily/nightly) **OR** severe/intense

SLEEP/WAKE HISTORY **SCORE**

When in your main SLEEP period do you:

1. Snore frequently? _____
2. Awaken gasping or choking? _____
3. Awaken with pain in your chest (pressure, squeezing, or heavy sensation)? _____
4. Awaken with your heart racing, pounding, skipping or beating irregularly? _____
5. Experience enuresis, bedwetting? _____
6. Have seizures or convulsions? _____
7. Have light, fragmented sleep? _____
8. Have 2 or more awakenings from sleep that you can recall? _____
9. Have heartburn more than once per week? _____
10. Awaken to urinate more than once per main sleep period? _____
11. Do other people report you stop breathing when you appear asleep? _____

When AWAKENING from your main sleep period:

12. Do you feel very groggy or confused? _____
13. Do you have severe headaches? _____
14. Do you have sleep which is not very restful? _____
15. Do you have a very dry mouth or throat? _____
16. Is your voice hoarse? _____
17. Do you have a dull ache in your forehead? _____

During your main AWAKE period:

18. Do you doze off, despite efforts to stay awake? _____
19. Have you fallen asleep or had brief lapses within the last 12 months, while driving and/or in other situations where doing so is very inappropriate? _____
20. Do you nap, despite efforts not to? _____
21. Do you feel moderately, or even severely, sleepy? _____
22. Do you experience abnormal levels of physical or mental fatigue? _____
23. Have you developed significant issues with concentration and/or memory? _____
24. Have you developed significant issues with irritability and/or depression? _____

SLEEP/WAKE HISTORY

Check those which you have had, currently have, or are being treated for:

☐ High blood pressure, hypertension	☐ Hard to control?
☐ Heart attack, myocardial infarction	☐ Less than 12 months ago?
☐ Chest pain, angina	☐ More than once monthly?
☐ Heart rhythm disorder (example: atrial fibrillation)	☐ Hard to control?
☐ Diabetes	☐ Hard to control?
☐ Stroke(s)	☐ Less than 12 months ago?
☐ Cerebrovascular disease, near stroke(s), transient ischemic attack	☐ Less than 6 months ago?
☐ Epilepsy, seizure disorder	☐ Less than 6 months ago?
☐ Memory loss, dementia, Alzheimer's	☐ Moderate or severe?
☐ Kidney, renal failure	
☐ Unexplicable loss/gain of 10+ lbs in past year	

ALLERGIES, please list:

Medications_____

☐ Adhesive Tape ☐ Adhesive, 'EKG', electrodes

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