THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Sleep Questionnaire

Patient Name ______________________________ *Date* ____________

Instructions

Sleep is important for healing, immunity, mood, cognition, and many other functions in your body. Please answer the following questions about your sleep as accurately and fully as possible. For "Yes" or "No" questions, please mark your answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and identify possible strategies to help you sleep better.

Sleep Problems

1. Do you have a sleep problem that a clinician has diagnosed? Yes No
   If yes, what? ______________________________
2. Do you feel that you have a sleep problem? Yes No
   If yes, how would you describe it? ______________________________
   Do you snore loudly or stop breathing while you sleep? Yes No
   Have you completed a sleep study? Yes No
   Do you use a CPAP machine? Yes No

Sleepiness

3. Do you feel well-rested in the morning? Yes No
4. Are there times during the day or evening that you feel sleepy? Yes No
   If yes, what times are these? ______________________________
5. What do you do to wake up when you feel sleepy? ______________________________
6. Have you ever had an accident at work or at home because you were sleepy? Yes No
   If yes, please explain: ______________________________
7. Do you take naps? Yes No
   If yes, for how many minutes? ______________ What time of day? ______________
8. Do you feel well-rested after a nap? Yes No

Insomnia

9. Can you usually fall asleep within 20 minutes of lying in bed? Yes No
   If not, how long does it take? ______________________________
10. If it takes longer than 20 minutes, what do you do while trying to fall asleep? (such as read, watch TV, look at your phone, get up, etc.) ______________________________
11. Do you ever feel so wired at night that it is difficult to fall asleep? Yes No
12. Have you had a saliva cortisol test? Yes No
    If yes, what was your nighttime level? ______________________________

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13. Do you currently take or have you tried any of the following sleep aids (or others) to fall asleep? Yes No

If yes, please complete the following information for the sleep aids you have taken:

- **Ambien® (zolpidem):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Sonata® (zaleplon):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Lunesta® (eszopiclone):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Belsomra® (suvorexant):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Valium® (diazepam):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Ativan® (lorazepam):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Restoril® (temazepam):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Tylenol® PM:** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Benadryl®:** Tried in the past Taking now?
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Calcium (before bed):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Magnesium (before bed):** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Valerian:** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Kava:** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Melatonin:** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **5-HTP:** Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Other:** ______________________ Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Other:** ______________________ Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No
- **Other:** ______________________ Tried in the past Taking now
  If taking now, how many times per week? ___________ What dosage? ____________ Is it effective? Yes No

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14. Do you wake up in the middle of the night? Yes No
If yes, how many times and for what reasons? ______________________________

15. Do you have any trouble falling back asleep when you wake up during the night? Yes No
If yes, how long does it usually take you? ______________________________

16. Does feeling the need to move your feet or legs at night keep you awake, or have you been diagnosed with restless legs syndrome? Yes No

17. Do you have disturbing dreams at night? Yes No

Caffeine and Other Stimulants

18. If you use any of the following stimulants, please specify how much (number of ounces, cups, etc.) per day, how many times per day, and at what times you typically consume or use them. If you do not use the stimulant, leave it blank.

- **Coffee:** Regular Decaffeinated
  How much per day? __________ How often per day? __________ At what times? __________
- **Caffeinated sodas (such as Coke®, Pepsi®, Mountain Dew®):**
  How much per day? __________ How often per day? __________ At what times? __________
- **Energy drinks (such as Red Bull®, Monster Energy®, Rockstar®):**
  How much per day? __________ How often per day? __________ At what times? __________
- **Caffeinated water:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Green tea:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Black tea:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Other tea:** __________
  How much per day? __________ How often per day? __________ At what times? __________
- **Chocolate:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Coffee/espresso ice cream:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Sudafed® or other over-the-counter cold medications:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Alcohol:**
  How much per day? __________ How often per day? __________ At what times? __________
- **Other stimulant:** __________
  How much per day? __________ How often per day? __________ At what times? __________

19. In the spaces below, please list what medications you currently take (if any) and at what times:

- Medication: __________ Time of day you take it: __________
- Medication: __________ Time of day you take it: __________
- Medication: __________ Time of day you take it: __________
- Medication: __________ Time of day you take it: __________

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Stress and Stress Reduction

20. What kind of stress have you been under in the past few months? ____________________

21. What do you do for stress management? ____________________

22. Do you have a journal to write in that is near your bed? Yes No

23. Do you exercise aerobically? Yes No
    If yes, what do you do? ____________________
    How often per week? __________ What time of day? __________

Sleep Hygiene

24. What time do you usually go to bed? __________ What time do you usually wake up? __________

25. Do you feel that you go to bed too late? Yes No
    If yes, what time would you like to go to bed? ____________________

26. Do you watch TV in the evenings? Yes No
    If yes, what hours do you watch it? ____________________

27. Is the TV in your bedroom or in a family room? ____________________

28. Do you use a tablet, cell phone, or other electronic devices while lying in bed before going to sleep? Yes No

29. Do you read in bed before trying to fall asleep? Yes No
    If yes, do you read on a tablet or phone that has a lit-up screen? Yes No

30. Do you wear or use a sleep-monitoring device? Yes No
    If yes, what type? ____________________

31. How many hours (per night) are you physically in your bed? ____________________

32. How many hours of the time spent in bed are you actually asleep? ____________________

33. On the weekend or days off, do you vary your sleep schedule? Yes No

34. Do you have much light coming into your bedroom at night? Yes No
    If yes, what is the source? ____________________

35. Do you have young children who wake you up? Yes No

Bedroom, Breathing, and Environment

36. Are there any unusual smells in your bedroom? Yes No
    If yes, please describe: ____________________

37. Do you use nasal strips to help you breathe? Yes No
    If yes, do they help you to breathe? Yes No

38. Describe the flooring (carpet, hardwood, etc.) in your bedroom: ____________________

39. How many rooms in your home have carpets, and how old are the carpets? ____________________

40. What type of heat is in your home (forced air, radiant, etc.)? ____________________

41. How often do you change the furnace filter in your home? ____________________

42. Have you seen any mold in your windowsills or basement? Yes No

43. Do you have a HEPA air filter for your bedroom? Yes No
    If yes, what brand is it, and how long do you run it each day? ____________________

44. What type of vacuum cleaner do you use? ____________________
    Does it have a HEPA filter in it? Yes No

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45. How often do you clean the dust in your bedroom? ___________________________

46. Do you sleep with an animal that snores or moves around and disturbs you? Yes No

47. Do you sleep with a bed partner who snores, moves around, or disturbs you when you are trying to sleep? Yes No

48. Do noises wake you up? Yes No

If yes, what are they? ___________________________

49. Do you live on a noisy street? Yes No

50. Do you feel safe in your bed at night? Yes No

If not, explain: ___________________________

Bed, Pillows, and Pain

51. What type of bed do you have, and what size is it? ___________________________

52. Do you wake up because of pain? Yes No

If yes, at what time and where is the pain? ___________________________

53. What type of pillow is most comfortable for you? ___________________________

What type of pillow have you tried that didn't work for you? ___________________________

54. Do you use body pillows? Yes No

If yes, how many? ________ How do you use them? ___________________________

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