SLEEP TEST

Compliments of Dr. Donna F. Smith, C.N., C.C.N.

Name:_____ Date: _____ to _____

INSTRUCTIONS: Do NOT Guess – have someone observe your sleep for accuracy. Where applicable, write your answer on the line or circle the answer(s).

1. What time do you regularly go to sleep and wake up? Sleep:_____ Wake: _____
2. Number of nights per week you follow this regular sleep and waking schedule? _____
3. When you sleep, do you:
   a. Have a light on in the room or can see a light in another room from your bed?
   b. Hear noises in the house, traffic, airplanes, etc.?
   c. Have animals that wake you in the night or before you are ready to wake?
   d. Hear your partner snoring?
   e. Stay awake or wake up because of your partner's snoring?
4. How long does it take you to go to sleep?
   a. 0 – 5 minutes b. 5 – 15 minutes
   c. 15 – 30 minutes d. 30 – 60 minutes
   e. 60+ minutes
5. How long do you stay asleep? _____
6. How long could you sleep if left undisturbed? _____
7. When do you feel hungry after you wake up?
   a. Within 30 minutes
   b. 30 minutes to 2 hours
   c. More than 2 hours
8. Do you dream when you sleep?
   a. No
   b. Yes, but I don't remember my dreams
   c. Yes, I have short dreams
   d. Yes, I have long, vivid dreams
   e. Yes, I have nightmares
9. Do you snore?
   a. No, I do not snore
   b. Yes, I snore lightly
   c. Yes, I snore heavily, followed by gasping for air
10. Do you have symptoms of narcolepsy?
    a. No, I do not have any symptoms
    b. Yes, I have excessive daytime sleepiness
    c. Yes, I am unable to remain awake, even after a normal night's sleep
    d. Yes, I sometimes catch myself falling asleep while driving during the day
11. Do you have periodic limb movement?
    a. No
    b. Yes, I am wakened from my sleep by limb movement episodes
    c. Yes, when I awake in the morning my arms and legs are aching
12. Do you suffer from sleep apnea (obstructive breathing)? YES / NO