



Judy & Richard
Votmer Sleep Center

Insomnia Questionnaire



NAME _____

AGE _____

Height _____ Weight _____

Inclusion Factors

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have insomnia?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had insomnia for more than six months? How long?
<input type="checkbox"/>	<input type="checkbox"/>	Does it take you more than 30 minutes to fall asleep?
<input type="checkbox"/>	<input type="checkbox"/>	Does it keep you awake more than 30 minutes during the night?
<input type="checkbox"/>	<input type="checkbox"/>	Does your insomnia occur more than three times a week?
<input type="checkbox"/>	<input type="checkbox"/>	Is your daytime function compromised as a result of your insomnia?
<input type="checkbox"/>	<input type="checkbox"/>	Is your insomnia getting worse?

Past Medical History

Do you have any sleep disorders (i.e. sleep apnea, restless leg syndrome, nightmares, sleep walking, sleep talking)? _____

If yes, how were you treated? _____

Do you have any neurological disorders (i.e. dementia, parkinson's, seizures), and if so what are they? _____

Do you have any psychiatric disorders (i.e. depression, anxiety, bipolar), and if so what are they? _____

Do you have a chronic pain disorder? _____

Do you have any other medical disorders, and if so what are they? _____

Medications

Please list the medications you take: _____

Do you take anything to help you fall asleep? _____

Answer these questions based upon your experience or your bed partner's experience. Check Yes or No.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	I feel restless at night or have an uncomfortable feeling in my legs at night
<input type="checkbox"/>	<input type="checkbox"/>	I am a shift worker or work in multiple time zones
<input type="checkbox"/>	<input type="checkbox"/>	I wake up at night have trouble falling back asleep
<input type="checkbox"/>	<input type="checkbox"/>	My legs move or jerk at night
<input type="checkbox"/>	<input type="checkbox"/>	When I go to bed I often have a lot on my mind
<input type="checkbox"/>	<input type="checkbox"/>	I wake up gasping for air
<input type="checkbox"/>	<input type="checkbox"/>	I snore
<input type="checkbox"/>	<input type="checkbox"/>	I stop breathing when I sleep
<input type="checkbox"/>	<input type="checkbox"/>	I wake up too early and can't fall back asleep
<input type="checkbox"/>	<input type="checkbox"/>	I feel tired during the day
<input type="checkbox"/>	<input type="checkbox"/>	I take naps
<input type="checkbox"/>	<input type="checkbox"/>	I tend to sleep in or want to sleep in when I can
<input type="checkbox"/>	<input type="checkbox"/>	I am sleepy when I decide to go to bed but by the time I'm actually in bed I am awake
<input type="checkbox"/>	<input type="checkbox"/>	When I travel or sleep in an alternative place other than my bed, I can sleep better
<input type="checkbox"/>	<input type="checkbox"/>	I urinate frequently at night

How much time do you think a person needs to sleep? _____

What recent medications have you discontinued if any and when? _____