HUS

Sleep Survey

Read the whole question before answering. Choose the most suitable alternative or write down the queried information based predominantly on the situation of the last three months. Make sure to mark down also the negative answers.

1. Date of completing the form __________ / __________ 20__________
2. Last name and first name ____
3. Social security number ____
4. Profession or job ____
5. Do you currently work in shifts? 1 yes 2 no
6. Do you have a driver's licence? 1 yes 2 no
7. Height (cm) ______________________ Your current weight (kg) ______________________
8. On average, how many hours do you sleep at night?

9. On average, how many hours do you sleep per 24 hours including naps during the day?

10. When do you sleep on weekdays? Draw a line to indicate the time you sleep.

20 21 22 23 24 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 o'clock

11. When do you sleep on your days off? Draw a line to indicate the time you sleep.

20 21 22 23 24 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 o'clock

12. Do you take naps during the day?

   1 never or less than once a month
   2 occasionally (less than once a week)
   3 sometimes (1 to 2 times a week)
   4 often (3 to 5 times a week)
   5 daily or almost daily

13. If you take naps during the day, how long do you sleep in general? _______ h _______ min

14. Do you feel tired during the day (you would like to rest but not necessarily sleep)?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 daily or almost daily

15. Do you feel sleepy during the day (so that would like to get some sleep)?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 daily or almost daily

16. Have you had an overwhelming tendency to fall asleep?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 daily or almost daily

17. Have you ever fallen asleep while driving a car or other motor vehicle?

1 never
2 yes, how many times? ________________

18. Have you ever been in a traffic or other accident because of fatigue?

1 never
2 yes, how many times? ________________

19. How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?

Even if you have not recently done some of the things described below, try to assess how they would have affected you. Choose the option that is the most appropriate one for you.

0 I would never doze off

1 a small chance of dozing off

2 a reasonable chance of dozing off

3 a great chance of dozing off

	0	**1**	**2**	**3**
Sitting and reading..	☐	☐	☐	☐
Watching television..	☐	☐	☐	☐
Sitting passively in a meeting, theatre or listening to a presentation..	☐	☐	☐	☐
As a passenger in a car continuously for one hour...........	☐	☐	☐	☐
Lying down to rest in the afternoon.........................	☐	☐	☐	☐
Sitting and talking to someone................................	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol................	☐	☐	☐	☐
Stopping the car for a few minutes at the traffic lights........	☐	☐	☐	☐

20. Have you had trouble falling asleep?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

21. How often do you wake up during the night?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

22. If you wake up during the night, how many times do you wake up?

1 I normally do not wake up during the night
2 once a night
3 twice a night
4 3 to 4 times a night
5 at least 5 times a night

23. Do you wake up too early in the morning not being able to fall back to sleep?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

24. Have you used sleeping pills?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

25. Do you feel the need to move your legs or uncomfortable sensations in your legs in the evening or at night?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

26. Do the sensations in your legs keep you from falling asleep disturb your sleep?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night

27. Do you snore when you sleep?

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night
6 I do not know

28. What is your snoring like (as described by someone else)?

1 I do not snore
2 I snore evenly
3 I snore very loudly and unevenly
4 I do not know

29. Are there breaks in your breathing when you sleep (sleep apneas)

1 never or less than once a month
2 occasionally (less than once a week)
3 sometimes (1 to 2 times a week)
4 often (3 to 5 times a week)
5 every night or almost every night
6 I do not know

30. Snoring assessment

Draw a vertical line on the rating scale to best describe your average situation during the last three months.

Another person's (e.g. your spouse's) assessment of how loud your snoring is

____

0 1 2 3 4 5 6 7 8 9 10

no snoring	very loud snoring, the person sleeping in the same bed with me will go to another room

31. Have you been diagnosed with any of the following diseases?

☐	diabetes	☐	depression
☐	heart failure	☐	hypertension
☐	asthma	☐	other long term disease, please specify what:

____

32. Have you ever had a sleep study (polygraphy) performed on you previously?

1 no

2 yes Where? ____

Year? ____

33. Have you had surgery to treat your snoring? When?

1 no

2 yes, in year ____________

34. Do you use an oral appliance for sleep apnea or a dental guard for bruxism when sleeping?

1 no

2 yes, an oral appliance for sleep apnea

3 yes, a dental guard for bruxism

35. Do you smoke?

1 I have never smoked

2 I have stopped smoking, when?____________________________

3 I smoke an average of_____________________ cigarettes per day

4 I have smoked for_____________________ years

36. How much coffee, tea or other invigorating drinks do you consume per day? ___________ cups

37. How many portions of alcohol (one portion = one bottle of beer, 12 cl of wine, 4 cl of spirits) do you consume per week?

1 I do not drink alcohol

2 less than 10

3 10-20

4 20-30

5 more than 30 portions

38. Do you have anything else you would like to report about your sleep and problems concerning it or about your vitality during the day?

39. Are you currently taking any medication regularly or almost regularly? Please state the names of the medicines. How often do you take the medication? Please also mention any medication taken in the evening or during the night and any non-prescription medicines.