THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Sleep Questionnaire

Patient Name_____ Date_____

Sleep is important for healing, immunity, mood, cognition, and many other physiological functions.

Please answer the following questions as accurately and fully as possible. For Yes / No questions, please check the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

Sleep Problems:

1 Do you have a sleep problem that has been 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 had a sleep study performed? ☐ Yes ☐ No
Do you use a CPAP machine? ☐ Yes ☐ No

Sleepiness Questions:

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, at home or on your job because you were sleepy? ☐ Yes ☐ No
If yes, please explain _____

7 Do you take naps? ☐ Yes ☐ No
If yes, for how many minutes and at what time of day? _____

8 Do you feel well rested after a nap? ☐ Yes ☐ No

Insomnia Questions:

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?
(e.g., read, watch TV, look at 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 night time level? _____

Insomnia Questions:

13 Do you currently take, or have you tried, any of the following sleep aids to fall asleep? ☐ Yes ☐ No
If yes, how many times per week do you take them? Please answer with an **E** for effective or an **N** for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien (zolpidem)				
Sonata (zaleplon)				
Lunesta (eszopiclone)				
Belsomra (suvorexant)				
Valium (diazepam)				
Ativan (lorazepam)				
Restoril (temazepam)				
Tylenol PM				
Benadryl				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				
5-HTP				
Others				

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? ☐ 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 drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use...	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas *(Coke, Pepsi, Mountain Dew, etc.)*			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19 What medications are you on and what time do you take them?

_____

_____

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 do you exercise, and at 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 use a light or 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 are you physically in your bed? _____

Sleep Hygiene:

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? ☐ 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 Breathe-Easy strips on your nose? ☐ Yes ☐ No If yes, do they help you to breath? ☐ Yes ☐ No

38 Do you have carpets or hardwood floors in your bed room? _____

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 or radiant? _____

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

42 Have you seen any black mold in your window sills or in a 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 and does it have a HEPA filter in it? _____

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 at night 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 and what type have you tried that did not work?
_____

54 Do you use body pillows? ☐ Yes ☐ No
If yes, how many and how do you use them? _____

IFM®