How well do you sleep?

Trouble falling asleep or staying asleep can affect both your nights and your days. Please answer the questions below and **bring this form to your next visit**. Your answers help your physician understand your symptoms and how best to support you.

Name _____ **Date of birth** _____ **Today's date** _____

1 What sleep problems do you have? (select all that apply)

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Waking up several times during the night
- ☐ Waking up too early
- ☐ Feeling tired or irritable during the day

2 How often do you have sleep problems?

○ Sometimes (2–3 times a month) ○ Often (about once a week) ○ Regularly (3 or more times a week)

3 On average, how many hours of sleep do you get each night?

○ More than 9 ○ 8–9 ○ 6–7 ○ 4–5 ○ Less than 4

4 How long have your sleep problems been going on?

○ Less than 3 months ○ 3 months or longer

5 What do you struggle with during the day because of your sleep? (select all that apply)

- ☐ Working or studying
- ☐ Caring for myself or my family
- ☐ Exercising
- ☐ Daily tasks
- ☐ Being social
- ☐ Memory or concentration

6 How often do other people notice that your mood is affected by your sleep?

○ Never ○ Sometimes ○ A lot

7 How does your sleep make you feel?

😀	🙂	😐	😕	☹️
○	○	○	○	○
Great	Good	Okay	Poor	Very poor

8 What have you tried to improve your sleep? (select all that apply)

- ☐ Limiting caffeine
- ☐ Meditation or breathing exercises
- ☐ Other: _____
- ☐ Limiting screen time before bed
- ☐ Medication(s): _____

This questionnaire is a tool to discuss with your physician — it is not a diagnosis. Bring it to your next appointment at Omotoso Family Medicine.