GLOBAL SLEEP ASSESSMENT QUESTIONNAIRE

Patient Initials: ___ ___ ___ Date: ___/___/___ Age:_____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____	Employment Status: ☐ Day shift ☐ Night shift ☐ Rotating shift ☐ Retired ☐ Unemployed ☐ Employed Full-time ☐ Employed Part-time ☐ Homemaker (Please check all that apply.)
Over the past month, have you had a major or stressful event that you feel affected your sleep? If so, please describe: _____	

INSTRUCTIONS: Please answer the questions below by writing on the line provided or by checking the box that best describes you. Please select only one answer for each question.

During the **PAST 4 WEEKS**, how often . . .

(Check one box on each line.)

1	Did you have difficulty falling asleep, staying asleep, or feeling poorly rested in the morning?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
2.	Did you fall asleep unintentionally or have to fight to stay awake during the day?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
3.	Did sleep difficulties or daytime sleepiness interfere with your daily activities?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
4.	Did work or other activities prevent you from getting enough sleep?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
5.	Did you snore loudly?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
6.	Did you hold your breath, have breathing pauses, or stop breathing in your sleep?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
7.	Did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
8.	Did you have repeated rhythmic leg jerks or leg twitches during your sleep?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
9.	Did you have nightmares, or did you scream, walk, punch, or kick in your sleep?	☐ Never	☐ Sometimes	☐ Usually	☐ Always
10.	Did the following things disturb your sleep:				
	a. Pain	☐ Never	☐ Sometimes	☐ Usually	☐ Always
	b. Other physical problems.....	☐ Never	☐ Sometimes	☐ Usually	☐ Always
	c. Worries.....	☐ Never	☐ Sometimes	☐ Usually	☐ Always
	d. Medications	☐ Never	☐ Sometimes	☐ Usually	☐ Always
	e. Other:	☐ Never	☐ Sometimes	☐ Usually	☐ Always
	_____ (Please specify)				
11	Did you feel sad or anxious?	☐ Never	☐ Sometimes	☐ Usually	☐ Always

This questionnaire was developed through a grant from Pharmacia Corporation