Papworth Hospital NHS
NHS Foundation Trust

RESPIRATORY SUPPORT & SLEEP CENTRE

Sleep Hygiene Questionnaire

		GOOD	
1. Do you wake at the same time each day?		YES	NO
2. Do you exercise each day?		YES	NO
3. Do you exercise close to bedtime?	YES	NO	
4. Do you have much caffeine in a day?	YES	NO	
5. Do you have caffeine after 8:00 pm?	YES	NO	
6. Do you set aside time daily to deal with stress e.g. list next day's tasks?		YES	NO
7. Do you smoke?	YES	NO	
8. Do you smoke after 8:30 pm?	YES	NO	
9. Do you have much to eat after 8:30 pm?	YES	NO	
10. Do you consume much fluid after 8:30 pm?	YES	NO	
11. Do you consume alcohol after 8:30 pm?	YES	NO	
12. Do you have time to un-wind before bedtime?		YES	NO
13. Do you have regular routines before bedtime, e.g. light snacks?		YES	NO
14. Do you have a hot shower or bath before bedtime?		YES	NO
15. Do you go to bed when drowsy?		YES	NO
16. Do you regularly nap in the day?	YES	NO	
17. Have you discussed with your doctor any outstanding medical issues which may affect your sleep?		YES	NO
18. Do you take non-prescription drugs?	YES	NO	
19. Is your bed comfortable?		YES	NO
20. Have you considered whether your bed partner is negatively affecting your sleep?		YES	NO
21. Is sexual tension preventing you from falling asleep?	YES	NO	
22. Do you engage in any stimulating activity before sleep, e.g. watching TV, arguments?	YES	NO	
23. Do you feel secure in your bedroom?		YES	NO
24. Is your bedroom quiet and cool?		YES	NO
25. Is your bedroom dark?		YES	NO
SUB-TOTAL	-	+	-
OVERALL SCORE			