

RPA Sleep Health and Respiratory Support Clinic

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PITTSBURGH SLEEP QUALITY INDEX (PSQI)

Name _____ ID# _____ Date _____ Age _____

Instructions:

The following questions relate to your usual sleep habits during the past month ONLY. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

Please answer all questions.

1. **During the past month, when have you usually gone to bed at night?**
USUAL BED TIME _____
2. **During the past month, how long (in minutes) has it usually taken you to fall asleep each night?**
NUMBER OF MINUTES _____
3. **During the past month, when have you usually gotten up in the morning?**
USUAL GETTING UP TIME _____
4. **During the past month, how many hours of *actual sleep* did you get at night? (This may be different than the number of hours you spend in bed.)**
HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer *all* questions.

5. **During the past month, how often have you had trouble sleeping because you.....**

(a) **cannot get to sleep within 30 minutes**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(b) **Wake up in the middle of the night or early morning**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(c) **Have to get up to use the bathroom.**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(d) **Cannot breathe comfortably.**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(e) **Cough or snore loudly.**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(f) **Feel too cold.**

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(g) **Feel too hot.**

Not during the Past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(h) **Had bad dreams.**

Not during the Past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(i) **Have pain.**

Not during the Past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

(j) **Other reason(s), please describe _____**

How often during the past month have you had trouble sleeping because of this?

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

6. During the past month, how would you rate your sleep quality overall?

Very good _____
Fairly good _____
Fairly bad _____
Very bad _____

7. During the past month, how often have you taken medicine (Prescribed or "over the counter") to help you sleep?

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all _____
Only a very slight problem _____
Somewhat of a problem _____
A very big problem _____

10. Do you have a bed partner or share a room?

No bed partner or do not share a room _____
Partner/ flatmate in other room _____
Partner in same room, but not same bed _____
Partner in same bed _____

11. If you have a bed partner or share a room, ask him/her how often in the past month you have had.....

(a) Loud snoring.

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

(b) Long pauses between breaths while asleep.

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

(c) Legs twitching or jerking while you sleep.

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

(d) Episodes of disorientation or confusion during sleep.

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____

(e) Other restlessness while you sleep: please describe _____

Not during the Less than Once or Three or more
Past month _____ once a week _____ twice a week _____ times a week _____