# *Mental Health Association of Northern Kentucky*

***A LEADER IN PROVIDING ADVOCACY, EDUCATION, AND SERVICES THAT PROMOTE MENTAL WELLNESS***

**EDUCATION AND SCREENING OUTREACH PARTNER FOR THE NATIONAL INSTITUTE OF MENTAL HEALTH AND NATIONAL MENTAL HEALTH ASSOCIATION**

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## SLEEPING PROBLEMS: DOCTOR'S CHECKLIST

To help your doctor create a personalized summary of your sleep problems, please answer the questions below by circling the appropriate response.

***Over the past month, how many cups of caffeinated coffee, or other caffeinated beverages, did you drink on average per day?***

0 - 1 2 - 3 4 - 5 6 or more

***Over the past month, how many drinks containing alcohol did you typically have per week?***

0 - 1 2 - 5 6 - 12 13 or more

***In the past month, how many times, if any, did you take over-the-counter medication for sleep?***

None Less than 6 6 - 14 15 - 20 20 or more

***In a typical month, how many prescription & over-the-counter medications of any kind do you take on a daily basis (for any reason)?***

None 0 - 1 2 - 3 4 - 5 6 or more

***Over the past month, how would you rate the quality of your sleep?***

Very good Fairly good Fairly poor Very poor

***Over the past month, how sleepy do you feel during the daytime?***

Not at all A little bit Quite a bit Constantly

You might also want to complete the sleep diary on the other side of this sheet before seeing your doctor. Generally we recommend completing the diary for 9 days so that your doctor can get a good idea of your routine, the problems you have, etc.