SLEEP QUESTIONNAIRE

Name:_____ Sex:____ Age:____ Date:_____

DOB:___/___/___ SSN:___-___-___ Address:_____

_____

Referring Physician:_____

Family Physician:_____

Height:_____ Weight:_____ Neck Size:_____ Phone:_____

Please fill in the blanks, and check appropriate areas on the questionnaire**.**

My main sleep complaint is:

__ stop breathing during sleep
__ trouble sleeping at night for how many months/years?_____
__ sleepy all day for how many months/years?_____
__ snore for how many months/years?_____
__ unwanted behaviors during sleep.
Explain:_____

I. Sleep Pattern	Work Days	Off Days (Weekends)
1. Typical Bedtime	_____	_____
2. Typical amount of time it takes to fall asleep	_____	_____
3. List any activities that you normally do during nighttime awakenings (restroom, eat, TV)	_____	_____
4. Typical amount of time it takes to fall back asleep after an awakening	_____	_____
5. Typical wake up time	_____	_____
6. Desired wake up time	_____	_____
7. How do you usually awaken (alarm clock, kids, etc)	_____	_____
8. Typical time you get out of bed	_____	_____
9. Total amount of sleep per night	_____	_____

II. Sleep Habits: Please check the column that you feel best describes your situation.

	Often	**Sometimes**	**Never**
1. I usually watch TV or read in bed prior to sleep.	_____	_____	_____
2. I frequently travel across two or more time zones.	_____	_____	_____
3. I drink alcohol prior to bedtime.	_____	_____	_____
4. I smoke prior to bedtime, or when I awaken at night.	_____	_____	_____
5. I eat a snack at bedtime.	_____	_____	_____
6. I eat if I awaken during the night.	_____	_____	_____
7. I typically awaken to urinate during the night.	_____	_____	_____
8. I feel that I have insomnia.	_____	_____	_____
9. I am unable to return to sleep easily if I awaken during the night.	_____	_____	_____
10. I awaken early in the morning, still tired, but unable to return to sleep.	_____	_____	_____
11. I have been unable to sleep for several days.	_____	_____	_____
12. I experience a creeping/crawling or tingling sensation in my legs when I try to fall asleep.	_____	_____	_____
13. I cannot sleep on my back.	_____	_____	_____
14. I am awakened at night by pain: Type:_____	_____	_____	_____

	Often	Sometimes	Never
15. I have trouble getting to sleep.	_____	_____	_____
16. I wake up more than once during the night.	_____	_____	_____
17. At bedtime, I feel sad and depressed.	_____	_____	_____
18. At night, my heart pounds, beats rapidly, or beats irregularly.	_____	_____	_____
19. I sweat a great deal at night.	_____	_____	_____
20. My sleep is disturbed by sadness or depression.	_____	_____	_____
21. I have nightmares (frightening dreams).	_____	_____	_____
22. I have slept, or been overwhelmingly sleepy for several days at a time.	_____	_____	_____
23. I get very sleepy during the day and I struggle to stay awake.	_____	_____	_____
24. I now have trouble doing my job because of sleepiness or fatigue.	_____	_____	_____
III. Breathing			
1. I have been told that I stop breathing while sleeping.	_____	_____	_____
2. I awaken at night choking, smothering, or gasping for air.	_____	_____	_____
3. I have been told that I snore.	_____	_____	_____
4. I have been awakened by my own snoring.	_____	_____	_____

	Often	Sometimes	Never
5. My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol.	_____	_____	_____
6. My snoring or breathing problem is much worse if I fall asleep on my back.	_____	_____	_____
IV. Restlessness			
1. I am a restless sleeper.	_____	_____	_____
2. I kick or jerk my legs and/or arms during sleep.	_____	_____	_____
3. I experience restlessness, tingling, or crawling in my arms or legs.	_____	_____	_____
4. I experience an inability to keep my legs still prior to falling asleep.	_____	_____	_____
5. I talk in my sleep (adult).	_____	_____	_____
6. I sleep walk (adult).	_____	_____	_____
7. I grind my teeth in my sleep.	_____	_____	_____
V. Daytime Sleepiness			
1. I take daytime naps.	_____	_____	_____
2. I have a tendency to fall asleep during the day.	_____	_____	_____
3. I have experienced lapses in time or blackouts.	_____	_____	_____
4. I have fallen asleep while driving.	_____	_____	_____
5. I often let someone else drive because I am sleepy.	_____	_____	_____
6. I have had auto accidents as a result of falling asleep while driving.	_____	_____	_____

	Often	Sometimes	Never
7. I have driven to the wrong place, and not remembered doing it.	_____	_____	_____
8. I performed poorly in school because of sleepiness.	_____	_____	_____
9. I have had injuries as a result of sleepiness.	_____	_____	_____
10. I have experienced an inability to move while falling asleep or waking up.	_____	_____	_____
11. I have experienced dreamlike images, sounds, or hallucinations while falling asleep or waking up.	_____	_____	_____
12. I get sudden muscular weakness (or even a brief period of paralysis) when laughing, angry, or in a situation of strong emotion.	_____	_____	_____

VI. Past Sleep Evaluation and Treatment

___ I have had a previous sleep disorder evaluation.
___ I have had previous overnight sleep studies.
If yes, When? _____
Where? _____
___ I have had daytime nap studies.
___ I have been prescribed a CPAP or Bi-Level machine for home use.
___ I have had surgical treatment for a sleep disorder.
___ I have previously been prescribed medication for a sleep disorder.

VII. Past Medical History: Please check all that apply.

___ Hypertension (High Blood Pressure)
___ Heart Disease
___ Diabetes
___ Stomach or Colon Problems
___ Lung Problems/COPD/Asthma
___ Reflux
___ Fibromyalgia
___ Glaucoma
___ Numbness
___ Fatigue, Weakness
___ Hearing Impairment
___Alcoholism
___ Stroke
___ TIA "Light Stroke"
___ Blackouts
___ Seizures
___ Back or joint problems (arthritis)
___ Cancer
___ Thyroid Problems
___ Hepatitis/Jaundice
___ Diziness
___ HIV Positive
___ Depression or severe anxiety
___ Chemical abuse or dependency

FEMALE: ___ Menstrual Periods
___ Post Menopausal

MALE: ___ Erectile Dysfunction/Impotence
___ Prostate Problems

Hospitalizations (Past Year):_____

_____

List other past medical problems, and dates: _____

_____

_____

List surgeries, and dates: _____

_____

_____

Any special needs: _____

_____

VIII. Current Medical Status

Medications	Dose	# Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

_____

Other Allergies:

_____

IX. Family History: Check if an immediate blood relative has had any of the following:

YES	NO		RELATION
___	___	Cancer	_____
___	___	Diabetes	_____
___	___	Hypertension	_____
___	___	Heart Disease	_____
___	___	Thyroid Disease	_____
___	___	Stroke	_____
___	___	Anxiety	_____
___	___	Depression	_____
___	___	Sleep Apnea	_____
___	___	Narcolepsy	_____
___	___	Other:	_____
			_____
			_____

X. Social History

Occupation: _____

Usual Work Hours/Days: _____

	YES	NO	AMOUNT/FREQUENCY
Caffeine	___	___	_____
Tobacco	___	___	_____
Alcohol	___	___	_____

Marital Status:
___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Do You… ___ sleep alone
___ share a bed with someone
___ share a bedroom, but have separate beds
___ share a dwelling, but have separate bedrooms

Employment Status:
___ Employed ___ Unemployed ___Retired

Check all that apply:
___ my job requires driving a vehicle
___ I work with dangerous equipment or substances
___ I am a shift worker on rotating shifts
___ I am permanent or long term third shift worker
___ I am currently a student

In the PAST 12 MONTHS, check any of the following symptoms you have had:

___ Frequent Headaches
___ Fainting or passing out
___ Sudden loss of hearing or ringing in ears
___ Hoarseness for more than 2-4 weeks
___ Nosebleeds
___ Cough for more than 2-4 weeks
___ Coughing up blood
___ Shortness of breath/wheezing
___ Swelling in feet/ankles
___Chest pain, pressure, or heaviness
___ Irregular heartbeat or sudden/fast heartbeat
___ Difficulty swallowing, or food "sticking"
___ Change in wart, mole, or skin growth
___ Frequent Heartburn/Indigestion
___ Abdominal Pain
___ Frequent Constipation
___ Frequent diarrhea
___ Rectal bleeding/black stools
___Difficulty urinating/incontinence
___ Blood in urine
___ Urinating more than twice/night
___ Pain in joints/bones
___ Unusual bruising/bleeding
___ Convulsions
___ Difficulty concentrating