

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	_____	_____

SLEEP QUESTIONNAIRE

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: _____	_____	_____	_____

SLEEP QUESTIONNAIRE

	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.	_____	_____	_____

SLEEP QUESTIONNAIRE

	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	_____	_____	_____

SLEEP QUESTIONNAIRE

	Often	Sometimes	Never
driving.			
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.

SLEEP QUESTIONNAIRE

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

- | | |
|---|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> TIA "Light Stroke" |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Stomach or Colon Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Lung Problems/COPD/Asthma | <input type="checkbox"/> Back or joint problems (arthritis) |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fatigue, Weakness | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Depression or severe anxiety |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical abuse or dependency |
| FEMALE: <input type="checkbox"/> Menstrual Periods | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Post Menopausal | |
| MALE: <input type="checkbox"/> Erectile Dysfunction/Impotence | |
| <input type="checkbox"/> Prostate Problems | |

Hospitalizations (Past Year): _____

List other past medical problems, and dates: _____

List surgeries, and dates: _____

Any special needs: _____

SLEEP QUESTIONNAIRE

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:	_____

SLEEP QUESTIONNAIRE

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