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Sleep Questionnaire

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

Date of birth: _____ Height: _____ Weight: _____ Neck size: _____

Referring Physician: _____ Primary Care MD: _____

MAIN SLEEP COMPLAINT(S)

- Trouble falling asleep Trouble remaining asleep
- Excessive sleepiness during the day
- Snoring
- Unwanted behaviors during sleep, such as _____
- Other, explain _____
- How long? _____

PRIOR SLEEP DISORDER DIAGNOSIS OR STUDIES

- I have a prior sleep diagnosis of _____
- Prior sleep studies (where, when) _____
- I am currently prescribed CPAP or Bilevel pressure. Settings _____
- Oxygen during the day or night _____ liters per minute.
- Yes No I have had surgery for a sleep disorder UPPP Tonsillectomy.
- Other _____
- Yes No I use a dental device for sleep disordered breathing.

SLEEP PATTERN

- Typical bedtime: _____ weekday _____ weekend
- Typical awakening time: _____ weekday _____ weekend
- Typical hours in bed: _____ hours. Typical hours of sleep: _____ hours
- Typical amount of time it takes to fall asleep _____ hours
- Typical number of awakenings per night _____

Time it takes to fall back asleep after awakening _____

Yes No My sleep pattern is irregular.

Yes No I awaken early in the morning still tired but unable to return to sleep.

SLEEP ENVIRONMENT HABITS

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Typical sleep position(s) back side stomach head elevated in a chair

I sleep alone. I share a bed with someone.

My bedroom is comfortable noisy too warm too cold

Yes No I have pets in the bedroom.

Yes No I watch TV in bed prior to sleep.

Yes No I read in bed prior to sleep.

Yes No I work or study in bed.

Yes No I drink alcohol prior to bedtime.

Yes No I smoke prior to bedtime or when I awaken during the night.

Yes No I eat a snack at bedtime.

Yes No I eat if I awaken during the night.

BREATHING

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Yes No I have been told that I snore loudly.

Yes No I have been told that I stop breathing while asleep.

Yes No I have been told that I snore only when sleeping on my back.

Yes No I have been awakened by my own snoring.

Yes No I awaken at night choking or gasping for air.

Yes No I awaken short of breath.

Yes No I have trouble breathing when flat on my back.

Yes No I have trouble breathing through my nose.

Yes No I have morning headaches.

Yes No I sweat a great deal at night.

DAYTIME SLEEPINESS

.....

Yes No I often feel drowsy during the day, more than I expect is normal.

Yes No I feel unrefreshed or tired in the morning despite sleeping at night.

Yes No I take I daytime naps. How many? _____

Yes No I have uncontrollable urges to fall asleep during the day.

Yes No I have experienced lapses in time or blackouts.

Yes No I have fallen asleep while driving.

Yes No I performed poorly in school or work because of sleepiness.

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate the most appropriate number for each situation.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	-----
Watching TV	-----
Sitting, inactive in a public place (e.g., a theater or meeting)	-----
As a passenger in a car for an hour without a break	-----
Lying down to rest in the afternoon when circumstances permit	-----
Sitting and talking with someone	-----
Sitting quietly after lunch without alcohol.....	-----
In a car, while stopped for a few minutes in traffic.....	-----
TOTAL (Range of 0 to 24)	-----

RLS

- Yes No I kick or jerk my legs excessively during sleep. This bothers my bed partner.
- Yes No I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.
- Yes No I experience an inability to keep my leg still prior to falling asleep.
- Yes No I experience the feeling of restlessness in my legs at night.

OREXIN RELATED

- Yes No I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise.
- Yes No I experience an inability to move while falling asleep or when waking up.
- Yes No I have experienced hallucinations or dreamlike images when falling asleep or waking up.
- Yes No I frequently dream during daytime naps.

PARASOMNIAS

- Yes No I act on my dreams while asleep.
- Yes No I have frequent nightmares.
- Yes No I talk in my sleep.
- Yes No I have sleep walked as an adult.

MISCELLANEOUS (Circadian, GERD, Depression, Enuresis, Bruxism, Pain)

- Yes No I frequently travel across two or more time zones.
- Yes No I am more alert in the morning than evening.
- Yes No I am more alert in the evening than morning.
- Yes No I awaken alert in the morning earlier than it is time to get up.
- Yes No I frequently have heartburn or acid reflux at night.
- Yes No I feel depressed.
- Yes No Chronic pain interferes with my sleep.
- Yes No The need to urinate frequently interrupts my sleep.
- Yes No I grind my teeth in my sleep.
- Yes No I have bedwetting (enuresis).

INSOMNIA

- Yes No I have trouble falling asleep.
- Yes No Thoughts start racing through my mind when I try to fall asleep.
- Yes No I have trouble remaining asleep.
- Yes No I awaken frequently during the night.
- Yes No I have difficulty returning to sleep if I awaken during the night.

HABITS

- Yes No I smoke cigarettes (or other tobacco). If yes, how much?
- Yes No I drink alcohol. If yes, how much and how often?
- Yes No I drink caffeinated beverages during the day _____ cups/bottles/cans
 - tea coffee soda per day

SOCIAL HISTORY
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Marital status Single Married Separated Divorced Widowed

Employment status: Employed: Occupation _____
 Unemployed Disabled Student Retired

Yes No I regularly work night shifts.

Yes No I work rotating shifts, including nice shiftwork.

PAST MEDICAL HISTORY
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- Hypertension Coronary artery disease Congestive heart failure Stroke Seizures
- COPD/asthma Diabetes Cancer Thyroid problems Depression or anxiety
- Alcoholism or chemical dependency Sinus disease Allergic rhinitis/nasal congestion
- Nasal fracture Reflux (GERD) Stomach or colon problems Fibromyalgia
- Back or joint problems (arthritis)

Other _____

Female Premenstrual syndrome Menopause

Male Prostate problems Erectile dysfunction

Prior surgeries _____

Weight change during the past year gained _____ pounds lost _____ pounds

CURRENT MEDICATIONS (OR LISTED ON SEPARATE SHEET)
.....

Medication	Dose	Times Per Day

Allergies: _____

FAMILY HISTORY
.....

Has an immediate blood relative had any of the following?

Obstructive sleep apnea Narcolepsy Other sleep disorders? _____
