



Sleep Questionnaire

Please complete prior to your scheduled sleep study. Answer as completely as possible and bring it with you. This will help us to understand your sleep problems.

Date _____ Name _____

Home phone # _____ Cell # _____ Work # _____

Address _____

DOB _____ SS# _____ Gender _____ Height _____ Weight _____ Neck Size _____

Emergency Contact & phone # _____

Referring Physician _____ Primary Physician _____

Describe the symptoms that brought you here. _____

(example: poor quality sleep, snoring, daytime sleepiness, etc.)

How long have these symptoms been a problem? _____

About Your Sleep

Weekday bedtime _____ rise time _____ *Weekend* bedtime _____ rise time _____

How long does it normally take you to fall asleep? _____

How many times do you awaken during the night? _____

Are these awakenings associated with (circle all that apply): *Snoring* *Gaspings/choking*

Need to urinate *Nightmares* *Leg discomfort* *Anxiety* *Pain*

How do you feel when you awaken in the AM? _____

How long before you get out of bed? _____

In the morning do you have (circle all that apply): *Headache* *Dry mouth* *Sore throat*

Do you nap during the day? **Y** **N** If yes, # days a week? _____ For how long? _____

While sleeping are you aware that you, or have you been told that you: (Circle all that apply)

Snore *Choke* *Stop breathing* *Jerk/move legs* *Are restless* *Perspire heavily*

Name _____ Date _____

Circle as appropriate:

Do you dream? *Usually Sometimes Rarely No*

Do you have nightmares? *Often Sometimes Rarely No*

Do you: *Grind your teeth Sleep talk Sleep walk Yell out*

Do you ever have VERY vivid dreams? *Often Sometimes Rarely No*

Have you ever had a feeling of paralysis while awake, particularly when laughing, excited, or surprised? **Y N** Describe _____

Do you ever awaken with a feeling of paralysis? *Often Sometimes Rarely No*

In what position(s) do you normally sleep? _____

Have you ever had a sleep study? **Y N** *When* _____ *Where?* _____

What were the results? _____

Have you ever used CPAP therapy? **Y N**

If yes, when _____ For how long? _____ Settings _____

Have you ever used oxygen at night? **Y N** *Explain* _____

Sleepiness & other problems (circle all that apply)

Do you awaken tired, regardless of how much sleep you've had? **Y N Sometimes**

Do you have difficulty staying awake during the day, esp. during meetings or at your desk?

Y N Sometimes Do you feel your work is affected by your sleepiness? **Y N**

Have you ever dozed off while driving? **Y N** *When?*

Do you have trouble concentrating/with your memory? **Y N**

Are you more irritable than you used to be? **Y N** Do you ever feel depressed? **Y N**

Have you had: *Decreased sexual interest Erectile dysfunction*

Do have a feeling of restlessness in your legs or arms when resting,

falling asleep, or during the day? **Y N** *Describe* _____

Name _____ Date _____

Habits affecting sleep

How much caffeine do you consume on an average day? _____

Do you use over the counter aids to stay awake? If so, describe. _____

Do you take any sleep aids? **Y N** Dosage/frequency _____

Do you exercise? **Y N** Note type and time of day _____

Do you use tobacco? (circle all that apply) **Y N** *Cigarettes* (____ *packs per day*)

Quit date _____ *Cigars (frequency)* _____ *Other* _____

Do you use alcohol: **Y N** What/how much/how often? _____

Are you a shift worker? **Y N** Explain _____

Distractions in sleep environment (children, neighbors, phone calls, snoring spouse, etc.)

Medical history

Have you gained or lost weight? *Gained Lost* How much? _____ Over how long? _____

Do you have a history of: (circle all that apply and explain below)

High blood pressure Heart problems Chest pain Stroke Head injury Seizures

Shortness of breath Lung disease Diabetes Arthritis Fibromyalgia Nasal/sinus problems

Kidney problems Depression Other psychiatric problems (name) _____

Explanations & other medical history _____

Surgeries & dates-don't forget tonsils & adenoids _____

Medications & dosages _____

Name _____ Date _____

This **Epworth Sleepiness Scale** is used to help identify your level of daytime sleepiness. Use the following scale to choose 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

<u>Situation</u>	<u>Chance of dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public	_____
Car passenger for an hour	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic	_____
Total	_____