Sleep Diagnostic center

SLEEP QUESTIONNAIRE

Please bring this for sleep appointment

Today's date: **Date of Sleep Testing:**

Name: ______________________________________ **Date of Birth:** ____________________

Current Weight: _________ **Maximum Weight:** ___________ **Height:** ________________

"X" OR CIRCLE THE CORRECT ANSWER OR WRITE REQUESTED INFORMATION.

PLEASE COMPLETE WITH BED PARTNER'S HELP. USE OPEN SPACES FOR COMMENTS.

1. Describe the sleep or wake problem that concerns you.

2. How long have you had this problem?

3. Do you snore? ☐ Never ☐ Occasionally ☐ Often
4. Have you been told you stop breathing in sleep? ☐ Never ☐ Occasionally ☐ Often
5. Do you sometimes have a headache when you awaken? ☐ Never ☐ Occasionally ☐ Often
6. Are you sleepy during the day? ☐ Never ☐ Occasionally ☐ Often
7. Are you sleepy when driving? ☐ Never ☐ Occasionally ☐ Often
8. Do you fall asleep unintentionally? ☐ Never ☐ Occasionally ☐ Often
9. How long does it take you to fall asleep at night? ______minutes _______hours
10. Do you awaken during your night's sleep? ☐ Never ☐ Occasionally ☐ Often
    A. How long does it take to get back to sleep? ______minutes _______hours
    B. Do you know why you awaken?
11. Are you restless during sleep? ☐ Never ☐ Occasionally ☐ Often

12. Do you, or have you been told that, you frequently kick your legs during sleep? ☐ Never ☐ Occasionally ☐ Often

13. Do you experience restless legs (crawling or aching feelings, or inability to keep legs still)? ☐ Never ☐ Occasionally ☐ Often

14. Do you experience vivid, dream-like scenes even though you think you are awake? ☐ Never ☐ Occasionally ☐ Often

15. Do you experience any kind of pain or physical discomfort? ☐ Never ☐ Occasionally ☐ Often

16. Do you have persistent, repeating or violent dreams? ☐ Never ☐ Occasionally ☐ Often

17. Have you ever acted out your dreams or woke up doing so? ☐ Never ☐ Occasionally ☐ Often

18. Do you awaken from sleep screaming, violent and confused? ☐ Never ☐ Occasionally ☐ Often

19. Have you ever had seizures or epilepsy? ☐ Never ☐ Occasionally ☐ Often
    A. When?

20. Have you been told that you grind your teeth in sleep? ☐ Never ☐ Occasionally ☐ Often

21. Do you have a sour or acid taste in your mouth during sleep? ☐ Never ☐ Occasionally ☐ Often

22. Do you have heartburn or chest pain during sleep? ☐ Never ☐ Occasionally ☐ Often

23. Do you gag, choke, or cough during sleep? ☐ Never ☐ Occasionally ☐ Often

24. Do you ever feel short of breath during sleep? ☐ Never ☐ Occasionally ☐ Often

25. **IS YOUR SLEEP DISTURBED DURING THE NIGHT BECAUSE OF:**

    A. Having thoughts racing through your mind? ☐ Never ☐ Occasionally ☐ Often

    B. Feeling sad and depressed? ☐ Never ☐ Occasionally ☐ Often

    C. Anxiety (worry about things)? ☐ Never ☐ Occasionally ☐ Often

    C. Do you have a fear of not being able to sleep once you have awakened during the night? ☐ Never ☐ Occasionally ☐ Often

26. How long altogether are you awake during your night's sleep time? _____minutes _____hours

27. What is the total number of hours of sleep that you usually get at night? (DO NOT include time that you spend awake in bed during the night.) _____minutes _____hours

28. What time do you usually go to bed? WEEKDAYS _____AM/PM WEEKENDS _____AM/PM

29. What time do you usually get up in the morning? WEEKDAYS_____AM/PM WEEKENDS_____AM/PM

30. How much of a problem do you have with FATIGUE (tiredness, exhaustion, lethargy) even when you are NOT sleepy? ☐ Never ☐ Occasionally ☐ Often

31. Do you have weak knees or episodes of muscular weakness (paralysis or inability to move) when laughing, angry, or in other emotional situations? ☐ Never ☐ Occasionally ☐ Often

32. Do you feel you have a sexual concern? ☐ Yes ☐ No

33. How MUCH stress do you have at the present time? ☐ Not much ☐ Some ☐ A lot

34. Are you claustrophobic? ☐ Yes ☐ No
    A. If yes, please explain:

35. Do you have to get up to go to the bathroom during your sleep period? ☐ No ☐ Yes How many times per night?

36. What other medical or psychological problems do you have?

37. What medicines do you use regularly?

    A. What medicines do you use from time to time?

38. Do you have nasal stuffiness or congestion during sleep? ☐ Never ☐ Occasionally ☐ Often

39. Do you smoke or have you smoked? ☐ Yes ☐ No
If yes, how long have you or did you smoke?

How many packs per day? When did you quit?

40. Do you drink alcohol? ☐ Yes ☐ No How much per week?

41. Do you use recreational drugs? ☐ Yes ☐ No Which ones?

42. Do you use caffeinated beverages? ☐ Yes ☐ No What type?

    How much per day? Last cup or glass of the day at? _____AM/PM

43. What is your occupation?

44. Are your working hours variable? ☐ Yes ☐ No

    Explain:

45. Have you had a sleep evaluation or study before this? ☐ Yes ☐ No

    A. When?

    B. What kind?

    C. Where?

46. REGARDING DROWSINESS RATHER THAN JUST FATIGUE, ENTER THE NUMBER THAT CORRESPONDS TO HOW LIKELY DROWSINESS IS TO OCCUR TO YOU IN THE FOLLOWING SITUATIONS:

0=NEVER OCCURS
1=OCCASIONALLY OCCURS (less than 50% of the time)
2=OFTEN OCCURS (50% OF THE TIME)
3=USUALLY OCCURS(more than 50% of the time)

A. Sitting and reading. _____
B. Watching TV _____
C. At a public place like a theater or meeting. _____

D. While a passenger in a car riding for one hour. _____
E. Lying down in the afternoon. _____
F. Sitting and talking to someone. _____
G. Sitting down after lunch. _____
H. While driving a car and stopped at a traffic light. _____
_____TOTAL

47. Describe what type of bed you sleep on (mattress, waterbed – waveless, etc.)

48. Do you sleep with a bed partner? ☐ No ☐ Yes

48. Use this space for anything you would lie to add.

50. Your address:

Your home phone number:
work number:

Best time to call: AM PM

51. Referred by:

_____ Self

_____ Friend

_____ Physician

Physician's Name____

Address____
____
City State Zip

Telephone (___)_______________________________

Did you choose this particular sleep center for our sleep study, or was this your doctor's choice?