

PATIENT SLEEP QUESTIONNAIRE

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

Occupation: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital status: Single Married Divorced Widowed

My Main Sleep Complaint(s) Is:

- | | |
|----------------------------------------------------------|------------------------------|
| <input type="checkbox"/> Trouble sleeping at night | How many months/years? _____ |
| <input type="checkbox"/> Being sleepy all day | How many months/years? _____ |
| <input type="checkbox"/> Snoring | How many months/years? _____ |
| <input type="checkbox"/> Unwanted behaviors during sleep | Explain: _____ |
| <input type="checkbox"/> Other; Explain _____ | |
- I have had a previous overnight sleep study. When/Where? _____

Please check all of the following statements that are true about your sleep:

Breathing

- I have been told that I stop breathing while I sleep
- I wake up at night choking, smothering or gasping for air
- I have been told that I snore mildly, occasionally frequently, moderately constantly, severely
- I have been told that I snore only when sleeping on my back
- I have been awakened by my own snoring
- My bedpartner is bothered significantly by my snoring

Daytime Sleepiness

- I have had "blackouts" or periods when I am unable to remember what just happened
- I have fallen asleep while driving or feel my driving is affected by sleepiness
- I have had an auto accident as a result of falling asleep while driving
- I fall asleep easily in quiet situations
- I perform poorly in school or work because of sleepiness
- I have had injuries as the result of sleepiness
- I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- I have had an inability to move while falling asleep or when waking up
- I have had hallucinations or vivid dreamlike images or sounds when falling asleep or waking up

Sleep Habits

- I usually watch TV or read in bed prior to sleep
- I have thoughts that start racing through my mind when I try to fall asleep
- I often drink alcohol prior to bedtime
- I wake up early in the morning, and I am still tired but unable to return to sleep
- I cannot sleep on my back I can only sleep on my back I need elevation of the head of my bed
- I sleep alone I share a bed with someone
- I am a shift worker on rotating shifts
- I frequently have trouble with insomnia

	<u>Work Days (Weekday)</u>	<u>Off Days (Weekends)</u>	
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.	
Typical amount of time it takes to fall asleep:	_____	_____	
Typical number of awakenings per night:	_____	_____	
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.	
Total amount of sleep per night:	_____ hours	_____ hours	
Number of naps per day/duration:	_____	_____	
Usual Work Days: _____	Usual Work Hours: _____		

Restlessness/Parasomnia

- I have uncomfortable feelings in my legs and/or arms when I lie down at night
- I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- I have a hard time falling asleep because of my leg movements
- Leg restlessness delays my sleep often occasionally rarely
- I have been told that I kick or jerk my legs and/or arms frequently during sleep
- I frequently talk in my sleep
- I have walked in my sleep as an adult
- I grind my teeth in my sleep I use a guard to protect my teeth from grinding
- I have acted out dreams physically while asleep
- I have injured myself or others with movement during the night

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____

Past Medical History (please indicate any medical problems you experienced)

- | | |
|------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hepatitis/jaundice |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression or severe anxiety |
| <input type="checkbox"/> Reflux/stomach or colon problems | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Lung problems/COPD/asthma | <input type="checkbox"/> Chemical dependency or abuse |
| <input type="checkbox"/> Chronic sinus disease | |
| <input type="checkbox"/> Fibromyalgia/chronic pain | <u>Female</u> |
| <input type="checkbox"/> Stroke or mini stroke (TIA)/head injury | <input type="checkbox"/> Perimenopausal/hot flashes |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Seizures | <u>Male</u> |
| <input type="checkbox"/> Back or joint problems (arthritis) | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Erectile dysfunction/impotence |

List any other important past medical problems/surgeries:

Current Medications (please list or provide a list)

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies: _____

Family History

Has an immediate blood relative had any of the following? Sleep Apnea _____
 Restless legs _____
 Narcolepsy _____

Habits

Do you smoke or have you smoked? Yes, currently No, never Previously
If Yes: Cigarettes _____ pack(s)/day _____ years

If Previously: When did you quit? _____ How much did you smoke? _____
For how many years did you smoke? _____

Do you drink alcohol? Yes No
If Yes: What? Beer Wine Liquor
Frequency? _____ drinks per Day Week Month

Do you drink caffeinated beverages during the day? _____ # of cups/bottles/cans/oz per day _____
Type of drinks: coffee tea soda My last caffeinated drink is usually: _____ am/pm

Vital Statistics

What is your: Height? ____ feet ____ inches Weight? _____ pounds Neck Size: _____