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SLEEP CENTER
Diagnosis & Treatment of Sleep Disorders
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SLEEP QUESTIONNAIRE

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Name: ______________________ Age: ______ Sex: ______ Date of Birth: ____________

Referring Physician: ______________________ Weight: ______ Height: ________

Neck Circumference or Collar Size: ____________ BMI: ____________ Today's Date: ____________

What is the sleep problem you are having? ______________________________________

____

SLEEP HABITS

1. What is your usual bed time? ________ am / pm
2. What is your usual wake time? ________ am / pm
3. How many hours do you think you sleep on average per night? __________ hours
4. How long does it usually take for you to fall asleep? ________ minutes
5. How often are you likely to awaken during the night?
   (choose only one) ❑ Rarely ❑ 3 or less times ❑ Frequently
6. Do other people tell you that you snore loudly? ❑ yes ❑ no
   How many years has loud snoring been noted? __________ years
7. Have you been told that you stop breathing during sleep? ❑ yes ❑ no
   How many years has this been noted? __________
8. Do you often awaken at night with a sensation of choking? ❑ yes ❑ no
9. Have you been told that your arms and legs jerk during sleep? ❑ yes ❑ no

DAYTIME SYMPTOMS & COMPLAINTS

10. Please answer the following questions with the understanding that FATIGUE means feeling "worn out" and SLEEPINESS means "a need to sleep or actually dozing off."

    What word best describes your level of daytime FATIGUE in the last month?

    ❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Very Severe

    What word best describes your level of daytime SLEEPINESS in the last month?

    ❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Very Severe

11. How long has daytime sleepiness been a problem for you? __________ years

12. Do you usually feel rested when you wake up? ❑ yes ❑ no

13. Do you usually take naps during the day? ❑ yes ❑ no

14. During the past month, how much has the sleepiness interfered with your normal work performance? (including your job and / or home activities)

❑ Not at all ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

15. During the past month, has sleepiness interfered with normal social activities with family, friends, or other groups?

❑ Not at all ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

16. Have you had accidents or near accidents because of sleepiness? ❑ yes ❑ no

17. Please review the following table to rate how likely you would be to actually doze off during each situation. Score your rating by circling a number from 0 to 3 points which best describes each situation and total your answers. Even if you have not done some of these things recently, try to recall how they would likely effect you.

0 points = Would never fall asleep
1 point = Slight chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High chance of falling asleep

SITUATION				
A. Sitting and Reading	0	1	2	3
B. Watching TV	0	1	2	3
C. Sitting, inactive in a public place (e.g., a theater or meeting)	0	1	2	3
D. As a passenger in a car for an hour without a break	0	1	2	3
E. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
F. Sitting down and talking to someone	0	1	2	3
G. Sitting quietly after lunch	0	1	2	3
H. In a car, while stopped for a few minutes in traffic	0	1	2	3
Totals:				

18. When you are angry, laughing or frightened do you feel weak as though you might fall? ❑ yes ❑ no

When you just fall asleep or just before you wake up do you:

19. Have bizarre dreams? ❑ yes ❑ no

20. Feel as if you are paralyzed? ❑ yes ❑ no

ARE YOUR LEGS KEEPING YOU UP AT NIGHT?

21. **4 Key signs you should discuss with your doctor:**

Do you sometimes have an urge to move your legs, often associated with uncomfortable leg sensations?	❑ yes	❑ no
Do you get relief, at least temporarily, from the urge of leg sensations when you move?	❑ yes	❑ no
Do your leg symptoms begin or get worse when you are resting or inactive?	❑ yes	❑ no
Do your leg symptoms get worse in the evening or at night?	❑ yes	❑ no

22. **Additional information to aid in understanding your symptoms:**

Do you have trouble falling or staying asleep?	❑ yes	❑ no
Does anyone in your family complain of any of the symptoms described above?	❑ yes	❑ no
Does your partner complain that you kick or jerk your legs while sleeping?	❑ yes	❑ no

23. **How would you describe your leg sensations?**
(Please check all that apply.)

❑ Creeping	❑ Crawling	❑ Tingling
❑ Aching	❑ Burning	❑ Pulling
❑ Painful	❑ Itching	❑ Other: ____________

23. **How often do you experience these symptoms each month?** ____________

PREVIOUS SLEEP DISORDER DIAGNOSIS & TREATMENT

24. Do you have a previous diagnosis of a sleep disorder? ❑ yes ❑ no
If “yes”, please describe: ____

____

25. Have you had surgery for your sleep problem? ❑ yes ❑ no
If “yes”, what was done and when was it done? ____________________________

____

26. Do you use oxygen while sleeping? ❑ yes ❑ no

27. Do you use a nasal CPAP or BIPAP for sleep apnea? ❑ yes ❑ no
If “yes”, what pressure level (s) do you use? ________________ cm of H^2O

28. Do you feel any difference when using CPAP? ❑ yes ❑ no
If “yes”, in what way? ____

PAST MEDICAL HISTORY

29. Have you had any of the following problems? (please check all that apply)

❑ Tonsillectomy	❑ Chronic lung disease (COPD, Emphysema)	❑ Heart Failure
❑ Asthma	❑ High Blood Pressure	❑ Thyroid disease
❑ Chronic nasal/sinus problems		
❑ Diabetes	❑ Angina / Heart attack	❑ Treatment for depression

30. List any major medical problems or illnesses you have had in the past that are not listed.

____

____

____

31. List all MEDICATIONS you are taking now. Be sure to list prescription and non-prescription medications including sleeping agents.

____

____

____

32. List any MEDICATION ALLERGIES you may have.

____

____

____

SOCIAL HISTORY

33. Do you drink alcoholic beverages? ❑ yes ❑ no

If "yes", how much per day? (1 ounce (oz) of alcohol is approx. equal to one beer / wine)

❑ 2 oz. or less ❑ 2-4 oz. ❑ More than 4 oz.

34. Do you drink caffeinated beverages? ❑ yes ❑ no

If "yes", how many glasses, cups or cans of each?

Coffee ________ Tea ________ Cola / Soft Drinks ________

35. Have you gained any weight over the last year? ❑ yes ❑ no

If "yes", how much? ________ pounds

36. Do other family members have similar sleep problems? ❑ yes ❑ no

37. What is your occupation? ______________________________

38. What are your working hours? ______________________________

39. Please use the following space to elaborate on other related information about your medical or sleep complaints.

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