Hartford Hospital
A Hartford HealthCare Partner
Sleep Disorder Center
Phone: 860-696-2820 Fax: 860-545-5080

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SLEEP QUESTIONNAIRE

Name: _____
Date of Birth: _____
Date completed: _____
Referring Physician: _____ M.D.

If the referring physician is not your primary physician and/or if you wish another physician to receive a copy of the results of this sleep study, please write his or her name and address below:

_____
_____

Please **complete** *the* sleep questionnaire and **bring** the questionnaire when you come to the sleep disorder center for your sleep test. This information is confidential.

Please complete *all* parts of the questionnaire. This information will help your doctor and the sleep specialist evaluate your sleep study.

Part 1 ***Summarize your sleep problem***
Describe what you (or your bed partner) believe is the *main problem* with your sleep.

_____
_____
_____
_____

Describe daytime problems you have.

_____
_____
_____

What is your regular bed time? _____ What is your regular wake time?_____
Are they different on the weekend, if yes, please list your weekend/days off bed time and wake time.

_____

Do you do shift work? Yes No If yes, please list the shifts you work _____

What is your current weight? _____ lb. What was your weight when you were twenty? _____lb.

Have you gained weight during the past 6 months? Yes No How many pounds? _____lb.

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Please list any health problems (*for example, high blood pressure, heart disease, diabetes, a thyroid condition, seizures, stroke, arthritis)* that you are being treated for now *or* that you have been treated for in the past.

_____ _____
_____ _____
_____ _____
_____ _____

*Please list operations you have had (**particularly** sinus, nose, facial or throat surgery)*

_____ _____
_____ _____

Prescription Medications (dose, frequency)

_____ _____
_____ _____
_____ _____

Seizure medications? Yes No Please list: _____
_____

Other Medications:

N = never or rarely **S** = sometimes **A** = often or always	**Check Best Answer**		
Aspirin, buffered aspirin, enteric-coated aspirin (Ecotrin, Bufferin, etc.)	**N**	**S**	**A**
For indigestion (antacids, Maalox, Riopan, Mylanta; H-2 blockers, including Pepcid, Tagamet, Axid, etc.)	**N**	**S**	**A**
Nasal decongestants (Afrin, NeoSynephrine)	**N**	**S**	**A**
Allergy or hay fever pills or tablets (including antihistamines)	**N**	**S**	**A**
Sleeping pills (Somenex, Tylenol PM, etc.)	**N**	**S**	**A**
Diet pills (prescription or non-prescription)	**N**	**S**	**A**
Name(s) of diet pills _____			
Non-prescription stimulants (NoDoz, Vivarin, caffeine tablets)	**N**	**S**	**A**
Oxygen?	**Yes**		**No**
Liters Per Minute (LPM) _____			
Have you had any sleep studies in the past?	**Yes**		**No**

When and where?

_____
_____
_____
_____

N= never or rarely **S**= ometimes **A** = often or always	**Check Best Answer**		
Do you **snore** during your sleep?	**N**	**S**	**A**
Is your snoring ***loud*** or does your snoring *bother others?*	**N**	**S**	**A**
Has anyone ever seen you **stop breathing** in your sleep?	**N**	**S**	**A**
Does your **nose block up** when you lie down or try to sleep?	**N**	**S**	**A**
Do you wake up choking or gasping for breath?	**N**	**S**	**A**

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Do you wake up with a **sour taste** in your mouth or with **heartburn?**	**N**	**S**	**A**
Do you wake up at night wheezing or coughing?	**N**	**S**	**A**
Do you **grind** your teeth during sleep?	**N**	**S**	**A**
Do you **wake up with a headache in the morning**?	**N**	**S**	**A**
Do you feel rested and alert after a full night's sleep?	**N**	**S**	**A**
Do you have **nightmares** (frightening dreams)?	**N**	**S**	**A**
Do you see vivid, dream-like images or scenes (**hallucinations**) as you fall asleep or as you wake up from regular sleep or naps?	**N**	**S**	**A**
Do you feel weak or **paralyzed** as you **wake up** or **fall asleep**?	**N**	**S**	**A**
Have you suddenly **become weak** when laughing at a joke or experiencing a very strong emotion (anger, fright)?	**N**	**S**	**A**

Did your sleep problem begin after a specific event? Yes No Please explain below:

_____
_____
_____
_____

How do you sleep when you are **away,** compared to sleeping at home?
❑ Better ❑ Same ❑ Worse

How often do you fall asleep in places **other** than your bedroom?	**N**	**S**	**A**
Do thoughts **race through you mind** when you try to fall asleep?	**N**	**S**	**A**
Do you worry about things when you are trying to fall asleep?	**N**	**S**	**A**
Do you feel **sad and depressed**, when you are trying to fall asleep?	**N**	**S**	**A**
Do you have trouble falling asleep because or **aches and pains**?	**N**	**S**	**A**
Does **light** disturb your ability to fall asleep?	**N**	**S**	**A**
Does **noise** interfere with your ability to fall asleep?	**N**	**S**	**A**

Do you ever feel a **restlessness** of your **legs,** (*nervous legs; a creeping or crawling sensation in your legs),* while you are lying in bed before sleep or when you wake up?	**N**	**S**	**A**

How many times per week does this occur?

0 1 2 3-4 5-6 always

Do arm movements or leg movements arouse you from sleep?	**N**	**S**	**A**

How many times do you wake up at night and then go back to sleep?

0 1 2-3 4-5 6-7 8-10 >10

Do bodily pains disturb you sleep? If yes, where?	**Yes**	**No**

_____

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N = never or rarely **S** = sometimes **A** = often or always

	Check Best Answer		
Do you use **non-drug therapies** (such as biofeedback, massage, magnets, acupuncture, or hot baths) to help you sleep?	**N**	**S**	**A**
Do you use **marijuana** to help sleep?	**N**	**S**	**A**
Do you use **alcohol** to help you sleep or nap?	**N**	**S**	**A**
How many drinks of alcohol do you consume per day?	**0**	**1-3**	**≥ 4**
Do you have difficulty **driving,** because of sleepiness or fatigue?	**N**	**S**	**A**
During the past 6 months how many **accidents or near automobile accidents** have you been involved, because of sleepiness? **0 1 2 3 4 5 >5**			
How many daytime naps do you take each day? **0 1 2 3 4 5 >5**			
Do you feel refreshed and awake after a daytime nap?	**N**	**S**	**A**
How many cups of coffee, tea or cocoa do you drink each day?	_____ cups		
How many cups of coffee, tea or cocoa within 2 hours of bedtime?	_____ cups		
How many cans of cola, (or other cold drinks with caffeine, for example Surge, iced tea, or Mountain Dew), do you drink, daily?	_____ cans		
Have you used recreational drugs, including marijuana, cocaine, heroin, angel dust, and crack) within the last 6 months? Please describe: _____	**N**	**S**	**A**
Do you sleep better after physical exercise?	**N**	**S**	**A**
Do you exercise, regularly?	**N**	**S**	**A**
Do you smoke cigarettes within 2 hours of bedtime?	**N**	**S**	**A**
Do you use tobacco products other than cigarettes? What tobacco products do you use? _____	**Yes**		**No**
Do **bladder problems** or incontinence disturb your sleep?	**N**	**S**	**A**
How many times do you wake up to urinate during the night? **0 1 2 3 4 5 >5**			
Are you unhappy about the loving **relationships** in your life?	**N**	**S**	**A**
Are you unhappy about your social life?	**N**	**S**	**A**
During the past six months, how much have your been bothered by:			
Increased irritability or lack of patience?	**N**	**S**	**A**
Increased difficulty remembering things?	**N**	**S**	**A**
Feeling sad?	**N**	**S**	**A**
Being less involved with family, friends or activities?	**N**	**S**	**A**
Having trouble concentrating on everyday tasks?	**N**	**S**	**A**
Difficulty making decisions?	**N**	**S**	**A**

Patient Signature: _____ Date: _____