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.
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

Aspirin, buffered aspirin, enteric-coated aspirin (Ecotrin, Bufferin, etc.)

Check Best Answer

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)

Check Best Answer

N  S  A

Name(s) of diet pills

Non-prescription stimulants (NoDoz, Vivarin, caffeine tablets)

N  S  A

Seizure medications? Yes No Please list:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Oxygen?

L = liters per minute (LPM) ____________________________________________

Check Best Answer

N  S  A

Yes No

Oxygen?

Have you had any sleep studies in the past?

Check Best Answer

N  S  A

Yes No

Have you had any sleep studies in the past?

When and where?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you snore during your sleep?

Check Best Answer

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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Please explain below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you wake up with a <strong>sour taste</strong> in your mouth or with <strong>heartburn</strong>?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you wake up at night wheezing or coughing?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you <strong>grind</strong> your teeth during sleep?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you <strong>wake up with a headache in the morning</strong>?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you feel rested and alert after a full night’s sleep?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you have <strong>nightmares</strong> (frightening dreams)?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you see vivid, dream-like images or scenes (<strong>hallucinations</strong>) as you fall asleep or as you wake up from regular sleep or naps?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Do you feel weak or <strong>paralyzed</strong> as you <strong>wake up</strong> or <strong>fall asleep</strong>?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Have you suddenly <strong>become weak</strong> when laughing at a joke or experiencing a very strong emotion (anger, fright)?</td>
<td>N</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td>Did your sleep problem begin after a specific event?</td>
<td>Yes</td>
<td>No</td>
<td>Please explain below</td>
</tr>
</tbody>
</table>

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?  
- How many times per week does this occur?  
  - 0  
  - 1  
  - 2  
  - 3-4  
  - 5-6  
  - always

How often do you 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

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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- 1  
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- 4-5  
- 6-7  
- 8-10  
- >10

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