SLEEP QUESTIONNAIRE

Your answers to the following questions will help us to obtain a better understanding of your sleep problems. Please answer every question to the best of your ability. It is helpful to discuss the answers with someone who has witnessed your problems, such as a spouse or bed partner.

BACKGROUND INFORMATION

Date: _____

Name:_____ Age:____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Physician:_____ Phone:( ) _____

Your Approximate Height: _____ Weight: _____ ☐gained ☐loss

Has your weight changed? ☐ Yes ☐ No If yes: How much? Over how long?

Have you ever had a sleep study ? _____Where? _____

Please briefly describe your sleep or sleep problem:

MEDICAL HISTORY

Have you ever been told by a doctor that you have:
(Check all boxes that apply)

☐ Hypertension (high blood pressure)
☐ Thyroid gland problems
☐ Heart attack
☐ Angina
☐ Stroke
☐ Cancer
☐ Asthma
☐ Emphysema or Chronic Bronchitis
☐ Depression or other psychiatric disorder
☐ Sinusitis
☐ Diabetes

Do you have other medial problems? If so, please list them here:

Have you ever had?

☐ Tonsillectomy (tonsils taken out)
☐ History or trauma
☐ Other surgeries:

Medications
List the medications that you currently take (including the ones you can get without a prescription):

Name	Dose	Name	Dose

Do you ever use sleeping pills, tranquilizers or sedatives? ☐Yes ☐ No If yes, please list.

Name	Dose	Name	Dose

Allergies
Please list all drugs that you are allergic to:

FAMILY HISTORY		
	Yes	No
Does anyone in your family snore or been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorder?	☐	☐
If yes, please list:		
Has anyone in your family been diagnosed with one of the disorders listed under the medical history?	☐	☐
If yes, please list:		

SOCIAL HISTORY			
Children:			
Please list those with whom you live			
HABITS			
Do you smoke?	**Present**	**Past**	**Never**
If present/past	**packs/day**	**years**	**quit**
How much of the following do you use		**Weekdays**	**Weekend days**
Coffee			
Tea			
Chocolate			
Caffeinated soda (pop)			
Alcohol			
Recreational drugs			

SLEEP HABITS	Work Days		Weekends	
What time do you go to bed?		am/pm		am/pm
What time do you get up?		am/pm		am/pm
How long does it take you to fall asleep?		Min		Min
On average, how many hours of actual sleep do you get nightly?		Hrs		Hrs
On average, how many times do you wake-up during the night?				
Do you return to bed after arising?	Yes ☐	No ☐	Yes ☐	No ☐
What time to you go to work or school?		am/pm		am/pm
What time do you return home?		am/pm		am/pm
Does your job require working different shifts?	Yes ☐	No ☐	Yes ☐	No ☐
If yes, which shifts?				
How many naps do you take ?				
during the day?				
during the evening?				
When did your sleep problem begin?				

SLEEP SYMPTOMS		IS IT GETTING WORSE	
		YES	NO
1	Do you snore?	☐	☐
2	Does your snoring or kicking prevent somebody from sleeping in the same bed with you?	☐	☐
3	Do you wake up gasping or feeling you cannot breathe?	☐	☐

4	Has your bed partner ever told you that you stop breathing during sleep?	☐	☐
5	Do you waken with a headache?	☐	☐
6	Are you sleepy during the daytime?	☐	☐
7	Do you have a restless or creepy feeling in your legs that is decreased by moving your legs or walking or prevents you from sleeping?	☐	☐
8	Has your bed partner ever noticed leg movement while you were sleeping?	☐	☐
9	Does your bed partner complain that you kick them during the night?	☐	☐
10	Do you toss and turn?	☐	☐
11	Do your legs feel restless before sleep?	☐	☐
	If so, please describe:		
12	Do you waken feeling tired, disoriented, and foggy?	☐	☐
13	Have you ever had an automobile accident related to sleepiness?	☐	☐
14	Have you ever had accidents at work related to sleepiness?	☐	☐
15	Do you ever find yourself somewhere and do not know how you got there	☐	☐
16	Do you have vivid dreams shortly after falling asleep at night?	☐	☐
17	Do you feel weakness in your muscles when you hear a joke, are excited, or emotional?	☐	☐
	If so, please describe:		
18	Do you ever feel that you cannot move after lying down or just after you awaken?	☐	☐
19	Do you feel paralyzed before sleep?	☐	☐
	If so, please describe:		
20	Do you hallucinate before sleep?	☐	☐
	If so, please describe:		
21	Do you ever feel sudden weakness in your limbs when Laughing or emotional?	☐	☐
22	When you waken, are you short of breath or wheezing?	☐	☐
23	Do you grind your teeth at night?	☐	☐
24	Do you have trouble going to sleep?	☐	☐
25	Do you awaken during the night for no apparent reason?	☐	☐
26	Do you awaken during the night and have trouble going back to sleep?	☐	☐
27	Do you awaken early in the morning and cannot go back to sleep?	☐	☐
28	Do you awaken at night with thoughts racing through mind?	☐	☐
29	Do you get up more than once a night to urinate?	☐	☐
30	Do you have difficulty falling asleep or awaken frequently through the night because of pain?	☐	☐
31	Do you watch T.V., read, eat, ect. in bed?	☐	☐
32	Do you fall asleep more easily on the couch or recliner than in bed?	☐	☐
33	Are you easily awakened by noise or light?	☐	☐
34	Do you feel frustrated or tense when seeing your bed or bedroom?	☐	☐
35	Have you felt depressed recently?	☐	☐
36	Have you been having any marital conflict lately?	☐	☐

37	Do you have very much job stress?	☐	☐
38	Do you find it difficult to get out of bed in the morning?	☐	☐
39	Is your job or school performance affected by your sleep problem?	☐	☐
40	Do you and your partner have similar bedtimes?	☐	☐
41	Have you ever been treated for snoring, sleep apnea, sleepiness or insomnia?	☐	☐
42	If you have a regular bed partner, do they sleep better or worse than you?		
43	How do you sleep away from home (e.g. on vacation)?		
44	What do you do after awakening in the night?		