Sleep Questionnaire

Name: ___________________________ Date: ________________
Birthdate: ________________ Age: ______ Occupation: ___________________
Sex: _______ Height: _______ Weight: _______ Weight Last Year: _______
Referring Doctor: _____________________ Family Doctor: ________________

Briefly, what is your sleep problem? _______________________________________

What results do you expect? ________________________________________________

A. MEDICATION SURVEY
Please list all of your PRESCRIPTION and NON-PREScription medications.

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B. PLEASE LIST PAST OR PRESENT MEDICAL CONDITIONS OR SURGERIES

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MEDICATION ALLERGIES: ____________________________________________

Page 1
C. SLEEP HABITS

1. Circle the days of the week you work:
   
   NONE Monday Tuesday Wednesday Thursday Friday Saturday Sunday

2. ON WORKDAYS
   a. What time do you go to bed: ____________________________
   b. What time do you get out of bed: _______________________

3. ON NON-WORKDAYS
   a. What time do you go to bed: ____________________________
   b. What time do you get out of bed: _______________________

4. How long does it take you to fall asleep? ____________________________

5. How many times do you awaken?
   a. How long do the awakenings last? _______________________
   b. List any symptoms upon awakening: _____________________

6. SLEEP TIME
   a. How many hours do you usually sleep? _______________________
      (Do not include hours spent in bed awake.)
   b. How many hours does it take to make you feel rested? ______
   c. How often do you take daytime naps? _______________________
   d. How long are the naps? ________________________________

7. SLEEP QUALITY
   a. Are you refreshed upon awakening in the morning? YES NO
   b. How long does it take to fully awaken in the morning? ______

8. Do you rarely fall asleep during the day, but suffer from extreme fatigue? YES NO

9. Grade your tendency of FALLING ASLEEP during the following situations:
   (0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

   a. Sitting and reading  
   b. Watching TV  
   c. Sitting inactive in a public place (e.g. theater or meeting)  
   d. Lying down to rest in the afternoon  
   e. Sitting and talking to someone  
   f. In a car, while stopped for a few minutes  
   g. Sitting quietly after a lunch without alcohol  
   h. As a passenger in a car without a break

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D. SLEEP AND BREATHING
1. Do you snore? *(If no skip to the next section.)*
2. Is your snoring broken by hesitations, gasps and snorts?
3. Are the hesitations long enough to frighten your sleep partner?
4. Has your snoring driven your bed partner from the bedroom
5. Do you awaken with a dry mouth?
6. Do you commonly have headaches upon awakening?

E. INSOMNIA
1. Do you have trouble falling or staying asleep? *(If no skip to the next section)*
2. Do you worry about being able to fall asleep on time?
3. Do you feel sleepy prior to bedtime?
4. Does your mind race with thoughts when lying awake?
5. Do daytime worries keep you awake at night?
6. Does pain disturb your sleep?
7. Does heat, cold, hunger or thirst disturb your sleep?
8. Is your insomnia the primary reason your life is in disarray?
9. Do you rely on a sleeping medication?
10. Do you watch TV, read, or work in bed.
11. Do you frequently travel across several time zones

F. SLEEP DISTURBANCES
1. Do unpleasant leg sensations at bedtime make you move your legs?
2. Do you kick or jerk your legs and/or arms during sleep?
3. Do you have sweats or awaken from sleep feeling flushed?
4. Do you awaken with a bitter or acid taste?
5. Do you frequently have nightmares or vivid dreams?
6. Do you grind your teeth or have bitten your cheek during sleep?
7. Have you ever *walked* or *talked* in your sleep?
8. Have you ever been unable to move for a few moments after awakening?
9. Have you ever seen or felt things from your dreams *after* awakening.
10. Have you ever had muscle weakness during laughter or anger?
11. Have you ever had unusual movements or behaviors during sleep. 
   Describe: 

G. PERSONAL HABITS
1. Do you use tobacco *now* or in the *past*?
   a. *If yes*, how much, how long, & when stopped?
   b. *If yes*, how close to bedtime is your last use?
2. Do you drink alcohol?
   a. *If yes*, how much?
   b. *If yes*, how close to bedtime is your last use?
3. Do you consume caffeinated beverages?
   a. *If yes*, how much?
b. If yes, how close to bedtime is your last use? __________________________________________

H. FAMILY HISTORY (Include age at passing and medical conditions)

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1. List relatives with sleep problems, who snore, or who have depression/anxiety?

________________________________________________________________________
________________________________________________________________________

1. PERSONAL HISTORY (Check any and all that apply)

- Skipped heart beats
- High blood pressure
- Epilepsy
- Nasal congestion
- Asthma
- Heart failure
- Thyroid problems
- Headaches
- Deviated nasal septum
- Depression
- Heart attack
- Diabetes
- Emphysema
- Enlarged tonsils
- Anxiety
- Heart murmur
- Stroke
- Sinusitis
- Allergies
- Bipolar disorder

J. BED PARTNER QUESTIONNAIRE (What does your bed partner see you do during sleep?)

- Light snoring
- Heavy snoring
- Pauses in breathing
- Snoring
- Teeth grinding
- Sleep walking
- Sleep talking
- Bed-wetting
- Head rocking/banging
- A shaking fit
- Leg or body twitching
- Leg jerking
- Daytime sleepiness
- Daytime confusion
- Depression/anxiety

1. Have your bed partner provide additional details of the above observations.

________________________________________________________________________

K. ADDITIONAL INFORMATION

________________________________________________________________________