SLEEP QUESTIONNAIRE

Patient's Name: _____

Age: _____ Height: _____ Weight: _____

1. Please circle any of the sleep problems that relate to you. Number the three problems that are the worst.

Sleep Apnea
Loud Snoring
Insomnia (falling asleep)
Insomnia (staying asleep)
Narcolepsy
Restless Legs
Sleep Terrors
Sleep-Wake Schedule Problems
Other_____

Daytime Fatigue
Poor Sleep Quality
Not Enough Sleep
Too Much Sleep
Nightmares
Sleep Walking
Leg Jerks

2. How long have you had this/these problem(s)?

_____

_____

3. Do you now or have you ever had any of the following conditions? If yes please describe.

High Blood Pressure	YES	NO
Sinus Problems	YES	NO
Allergies	YES	NO
Heart Problems	YES	NO
Lung Problems	YES	NO
Tonsillectomy	YES	NO
Nasal Fracture	YES	NO
Nasal Surgery	YES	NO
Diabetes	YES	NO

4. Please list any other medical problems. How Long?

_____

_____

_____

_____

_____

5. Please list all of your medications.

_____
_____
_____
_____

6. Please list any previous surgeries.

_____
_____
_____
_____
_____

7. Sleep Enviroment

Do you read in bed?	YES	NO
Do you watch TV in bed?	YES	NO
Do you share the bed with anyone?	YES	NO
Does your partner have a sleep disorder?	YES	NO
Do you have pets in the bedroom?	YES	NO

What is the temperature in your room? _____

8. Social History

Have you ever smoked?	YES	NO
If yes, average packs per day? _____		
Have you quit smoking?	YES	NO
If yes, how long ago? _____		
Do you drink alcohol?	YES	NO
If yes, how many drinks per day? _____		
Do you drink caffeinated beverages?	YES	NO
If yes, how beverages per day?_____		

9. What is your present occupation? _____

10. What are your work hours? _____

11. Family History

Marital Status

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Number of of Children:_____ Ages : _____ Health: _____

Mother: Living? YES NO Age: _____ Health: _____
Father: Living? YES NO Age: _____ Health: _____
Brothers: Living? YES NO Age: _____ Health: _____
Sisters: Living? YES NO Age: _____ Health: _____

_____
_____
_____

12. Please answer the following questions using a scale from 0 to 4.
0= Not At All 2 = Sometimes 4= All the Time

Are you sleepy during the day?	0 1 2 3 4
Do you feel fatigued?	0 1 2 3 4
Do you have a problem falling asleep?	0 1 2 3 4
Do you snore?	0 1 2 3 4
Do you hold your breath or stop breathing while you sleep?	0 1 2 3 4
Do you have gas, indigestión, or heartburn?	0 1 2 3 4
Do you have night sweats?	0 1 2 3 4
Do you awake with headaches?	0 1 2 3 4
Do you have trouble breathing?	0 1 2 3 4
Do you have trouble breathing through your nose?	0 1 2 3 4
How many times do you wake to urinate?	0 1 2 3 4
Do you have difficulty breathing while lying flat on your back?	0 1 2 3 4

Do you feel short of breath?	0 1 2 3 4
Do you ever choke on your food?	0 1 2 3 4
Have you ever wakened and felt paralyzed or unable to move?	0 1 2 3 4
While trying to fall asleep, do you ever have vivid dreams or hallucinations?	0 1 2 3 4
Do you have frequent, uncontrollable bouts of sleep, sleep attacks. or an irresistible urge to sleep?	0 1 2 3 4
Do you have muscle weakness when laughing?	0 1 2 3 4
Do you awaken gasping for air?	0 1 2 3 4
Do your legs kick or twitch at night?	0 1 2 3 4
Do your legs feel restless at night?	0 1 2 3 4
Do you have problems concentrating?	0 1 2 3 4
Do you have problems with impotence or lack of sexual interest?	0 1 2 3 4
Are you irritable?	0 1 2 3 4
Do you feel depressed?	0 1 2 3 4
Do you feel anxious?	0 1 2 3 4
Do you grind your teeth at night?	0 1 2 3 4
Have you ever caused a motor vehicle accident because you were tired?	0 1 2 3 4

13. Sleep History

What is your usual bedtime on weekdays/workdays? _____

What is the usual length of time to fall asleep? _____

What is your usual wake up time? _____

What is the average of number of times you wake in a night? _____

Do you feel refreshed in the morning? YES _____ No _____

Do you nap during the day? YES_____No_____

If yes, how many naps, _____ and what is the duration of the naps? _____

Are the naps refreshing? YES _____ No _____

What is your usual bedtime on weekends/days off? _____

What is your usual wake up time on weekends/days off? _____

What is the usual sleep time per 24 hours during weekends/days off? _____

How many hours of sleep do you need to feel rested? _____

Please list any medication allergies.

_____

_____

_____

_____

SLEEPINESS SCALE

0 Would Never Doze
1 Slight Chance of Dozing
2 Moderate Chance of Dozing
3 High Chance of Dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (theater, meeting, or classroom).	0 1 2 3
As a passenger in a car for an hour without a break.	0 1 2 3
Lying down for a rest in the afternoon when circumstances permit.	0 1 2 3
Sitting and talking with someone.	0 1 2 3
Sitting quietly after lunch without alcohol.	0 1 2 3
In a car stopped for a few minutes in traffic .	0 1 2 3