

Patient Sleep Questionnaire (To be completed by the patient before their study)

Life and Work Habits

1. Do you smoke or use other forms of tobacco? YES NO
If yes, what form? _____ How much? _____
2. Do you exercise? YES NO
If yes, how often? SELDOM OFTEN DAILY
3. Describe your type of work and hours: _____

4. What is your primary sleep complaint? _____

5. What is the reason your physician recommended this sleep study? _____

6. Do you drink caffeinated beverages? YES NO
If yes, what caffeinated beverages do you drink and how much per day? _____

7. Do you drink alcoholic beverages? YES NO
If yes, what alcoholic beverages do you drink and how much per day? (beer, wine, mixed drinks):

Problems Falling Asleep

1. Do you have trouble relaxing and feeling ready to go to sleep? YES NO
2. Do you hear, see or feel things that may not be real as you are falling asleep?
For example hearing voices or feeling that someone is in the room. YES NO
3. Do you often have trouble falling asleep due to racing thoughts? YES NO
4. Do you often have trouble falling asleep because of pain or discomfort? YES NO
- Elaborate when necessary: _____

Sleep Hygiene

1. Do you perform the following in bed? Check all that apply.
- | | | | |
|-----------------------------------|--------------------------------|--|------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Read | <input type="checkbox"/> Have arguments in bed | <input type="checkbox"/> Eat |
| <input type="checkbox"/> Watch TV | <input type="checkbox"/> Worry | <input type="checkbox"/> Write | |
2. When is your normal bed time (whether it is on the couch, on a recliner, in a bed, etc.)? _____ PM AM
When is your normal wake time? _____ PM AM

Sleep Habits

1. How long does it take you to fall asleep? _____ HOURS _____ MINUTES
 2. How many hours on average do you sleep per night? _____ HOURS _____ MINUTES
 3. Please check all of the positions you are *unable* to sleep in. BACK SIDE STOMACH
Why? _____

 4. Are you having trouble remembering misplaced items or events? YES NO
 5. Have you ever had the sensation of weakness while you were laughing, angry or feeling sad?
For example laughing very hard at a joke and feeling weak in your legs. YES NO
 6. Do you usually feel sleepy anytime during the day? YES NO
 7. Do you usually need a nap during the day? YES NO
 - 7a. Do you usually find naps refreshing? YES NO
- Elaborate when necessary _____

Problems During Sleep

1. Do you wake up during sleep and have trouble falling back to sleep? YES NO
2. Do you wake up too early and have trouble falling back to sleep? YES NO
3. Do you frequently check the clock? YES NO
4. Do you have difficulty sleeping due to discomfort in legs or arms? YES NO
5. Have you ever walked in your sleep? YES NO
6. Do you have nightmares? YES NO
7. Do you have a history of wetting the bed?
If yes, when? YES NO
 CHILD ADULT
8. Do you grind your teeth?
If yes, do you use a mouth device to prevent this? YES NO
 YES NO
9. Have you ever thrashed, thrown covers off or fallen out of bed? YES NO
10. Have you ever hit or kicked your bed partner, or injured yourself during sleep? YES NO
11. Have you ever awakened screaming? YES NO
12. Do you snore? YES NO
13. Has anyone ever said you stop breathing while sleeping? YES NO

Problems After Waking Up

- 1. Do you normally wake up with headaches? YES NO
- 2. Have you ever awakened confused or disoriented? YES NO
- 3. Have you ever awakened feeling like you are awake but you cannot move? YES NO
- 4. Do you feel tired when you wake up? YES NO

Daytime Sleepiness

Please check the following questions based on this scale:

0. Would never fall asleep 1. Slight chance of dozing 2. Moderate chance of dozing 3. High chance of dozing

	0	1	2	3
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting inactive in a public place (ex. Theater)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after lunch (when you've had no alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In a car while stopped in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Disturbances

My sleep is frequently disturbed by (check all that apply):

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Need to urinate | <input type="checkbox"/> Pets | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Sinus or cold symptoms | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Leg discomfort | <input type="checkbox"/> Pain | <input type="checkbox"/> Cough | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Choking or gasping for air | <input type="checkbox"/> Hunger | <input type="checkbox"/> Children | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Frightening dreams | <input type="checkbox"/> Bed partner | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of Breath |

Please list any other symptoms that disturb your sleep not listed here: _____

Medical History

Please check all that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nasal/Sinus problems | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Other nose or throat surgery |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Have you ever had surgery for Sleep Apnea? | |

Family Sleep Disorder History

Please list any diagnosed sleep disorders in your family. If you do not know the diagnosis, describe the symptoms.

Medications

Please list all prescribed medications you are currently taking. (Dosage not required.)

Please list all non-prescription medications you have taken in the last 48 hours before your sleep study. (Over-the-counter, herbal, homeopathic, etc.)

Sleep Disorder Awareness

How did you become aware that you might have a sleep disorder and may need a sleep study?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Your Physician | <input type="checkbox"/> Media (radio, TV, newspaper, magazine) | <input type="checkbox"/> Website/Internet | <input type="checkbox"/> Family/Friend |
|---|---|---|--|