Confidential Sleep Questionnaire

Name:____ **Date:**_____________

Address:______________________________________

_______________________________________ **Zip:** _____________

Telephone: Home________________________ **Work**___________________

Occupation:______________________________ **Date of Birth:**____________

Height:_________**inches** **Weight:**_________**pounds** **Sex (M/F):**_______

Marital Status: __________ **Education:**__________________________

Referring Physician:____

Clinic Name: ____

Clinic Address: ____

____

Clinic Phone: **( )-**___________________________________

(We will send a copy of your test to this physician.)

* * * IMPORTANT * * *

The following questionnaire needs to be completed prior to your appointment. We cannot admit you without it - ***so please complete ahead of time and bring it with you to your appointment.***

Thank you!

I. Medications and Past / Current Medical History:

Clearly PRINT all medications you are currently taking (this includes prescription, non-prescription, vitamins, supplements, and PRN / "as needed" meds), along with exact dosages (taken from the bottles), the times you take them, and the purpose for each.

Medication Names (printed):	Dosage:	Time:	Reason for taking:
________________	_____	______ am / pm	______________
________________	_____	______ am / pm	______________
________________	_____	______ am / pm	______________
________________	_____	______ am / pm	______________
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________________	_____	______ am / pm	______________
________________	_____	______ am / pm	______________
________________	_____	______ am / pm	______________

List all medical conditions and/or health problems you are either currently being treated for or have been treated for in the past (please be very specific). ❑ **None**

Conditions:	Year of Diagnosis:
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

List all surgeries you have had, along with approximate dates. ❑ **None**

Surgeries:	Year:
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

If more space is needed for any of these areas, please attach a separate sheet.

II. Sleep Problem:

Please describe the problem(s) you are having with your sleep:________________

____

What have you tried in the past to correct your sleep problem(s)? ______________

____

Have you had a sleep study before? Yes No *If yes – where?* __________________

when? __________________

III. General Information

What time do you go to bed on weekdays? ________am/pm; Weekends:________am/pm

What time do you wake up on weekdays? ________am/pm; Weekends:________am/pm

How long does it normally take you to fall asleep? __________________________

How many times do you wake up during a typical night (circle)? 1 2 3 4 5 more

Does anything awaken you at night? Yes No *If yes, what?* ___________________

If yes, which part of the night do you wake up … first, middle, or last third? ____________

Is it hard for you to wake up in the morning? Yes No

Do you need an alarm clock to wake up? Yes No

Do you often wake up with a headache? Yes No *If yes, how often?* _____

Is the quality of your sleep satisfactory? Yes No

Do you feel you have insomnia? Yes No

Comments: ____

IV. Nighttime Symptoms

Do you snore loudly at night? Yes No Don't Know

Does a bed partner complain of your loud snoring? Yes No

Do you ever stop breathing in your sleep? Yes No Don't Know

Do you ever wake up choking or gasping for air? Yes No

If yes, how often? _______________________

Have you ever been unable to move shortly after going to sleep or when waking up?
Yes No If yes, how often does this happen? _____________

Do your legs jerk or twitch during sleep? Yes No Don't Know

Do you grind your teeth during sleep? Yes No Don't Know

Have you ever been told or are you aware that you have ever had a convulsion (fit,seizure,epilepsy) at night? Yes No

Do you ever wake up with a sour taste in your mouth, or a dry throat? Yes No

Do you have vivid dreams shortly after falling asleep? Yes No

Do you have frightening dreams or nightmares? Yes No

Have you ever had night terrors or screaming in your sleep? Yes No

As an adult, have you ever wet the bed during sleep? Yes No

How many times do you awaken at night to go to the bathroom? ______________

Comments: ____

V. Daytime Symptoms

Are you drowsy or sleepy during the day? Yes No

Does daytime sleepiness interfere with your work? Yes No

Have you fallen asleep while driving or eating? Yes No

Do you nap during the day? Yes No
If yes, how many & how long? ___________ Nap(s) *_____________ minutes*

Does a nap make you feel more alert? Yes No

Do you have vivid dreams during a nap? Yes No

Do you drink coffee, cola, or take caffeine tablets to stay awake? Yes No

Do you ever fall or lose muscle strength when laughing, when angry, or when emotionally upset? Yes No

VI. Emotional

Are you living under unusual pressure or stress from work or family? Yes No
Comments: ____

Do you now have, or have had in the past, serious depression? Yes No

Do you now have, or have had in the past, major anxiety? Yes No

Do you feel inadequate, tense or worried? Yes No

Is your sleep problem causing emotional problems? Yes No

Comments:____

VII. Lifestyle and Habits

Do you smoke or use tobacco (circle one)? Yes No Quit -when?________

If yes, what? _________ *How many?* _________________ *How long?* _________

Do you drink alcoholic beverages? Yes No *How much?*_________

Do you drink alcoholic beverages, coffee, tea or soft drinks after supper?
Yes No *How much?* ________*ounces*

How many cups of coffee, tea or cola do you drink on an average day? ______cups/cans

Do you work rotating shifts? Yes No

Do you frequently travel across time zones? Yes No

Do you exercise strenuously in the evenings? Yes No

Do you use any street drugs? Yes No
If Yes, what? ____

Comments:____

VII. Chronobiological

Do you function better in the morning, afternoon, or evening? (circle one)

Is your bedtime irregular? Yes No Please describe: ________________

Do you sleep different hours on weekends than on weekdays? Yes No

Do you frequently travel across time zones? Yes No

Does your job require shift work, night work, or work hour changes? Yes No

If yes, please describe your work/sleep pattern:____________________________

VIII. Past History and Family History

Have you ever been treated for a sleep problem before? Yes No
If yes, where & by whom? ____

Have you had previous sleep recordings or EEG's (brain wave tests)? Yes No
If yes, what did they show? ______________________________________

How long have you been aware of your sleep problem?__________Years

How much weight have you gained since high school? _________Pounds

Have you had your tonsils/adenoids removed? Yes No

Have you ever been knocked out or had any serious head injury? Yes No
If yes, please describe: ____

Have you ever had a serious viral illness? Yes No
If yes, please describe: ____

Did you ever have a problem sleeping as a child? Yes No
If yes, please describe: ____

Does anyone else in your family have similar sleep problems? Yes No
If Yes, Whom and What? ____

Please list any other information you feel it would be important for us to know about you:
____
____
____