



ADULT PATIENT SLEEP QUESTIONNAIRE

TOLL FREE FAX: 866-799-0601
PHONE: 877-SLEEPHC or 877-753-3742
info@sleephealth.com – www.sleephealth.com

The information you provide is VERY important and will assist the sleep specialist during the review of your sleep symptoms and data. This questionnaire has been compiled based on many years of accumulated experience in sleep medicine. Please respond to all questions. This information will be treated with the utmost discretion and will not be used by any party other than Sleep HealthCenters.

DEMOGRAPHICS

Today's Date _____

Sex: Female Male Date of Birth _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Email _____

PHYSICIAN INFORMATION

Referring Physician

Name _____

Address _____

Phone _____

Primary Care Physician

Name _____

Address _____

Phone _____

PERSONAL

Height | _____ | feet | _____ | _____ | inches Weight _____ lbs

Occupation _____

Marital status

- Single
- Married
- Divorced
- Widowed

Race (Origin)

- African American
- Asian / Pacific Islander
- Caucasian
- Hispanic
- Other

Education

- Less than high school
- High school or GED
- Bachelor's degree
- Master's degree
- Doctorate degree

SLEEP PROBLEMS (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Gasping / choking / repeated pauses in breathing while sleeping |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Unusual behavior(s) during sleep (walking, talking, etc.) |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Morning headache |
| <input type="checkbox"/> Tired/sleepy during the day | <input type="checkbox"/> Other _____ |

In your own words, briefly describe your sleep-related problem:

GENERAL HABITS

- | | | |
|--|---|---|
| 1. Please describe your predominant work schedule. | <input type="checkbox"/> Day shift (9 – 5) | <input type="checkbox"/> Variable schedule |
| | <input type="checkbox"/> Evening shift (3 – 11) | <input type="checkbox"/> Unemployed / retired |
| | <input type="checkbox"/> Night shift (11 – 7) | |
| ----- | | |
| 2. How many cups of caffeinated beverages do you drink per day? | <input type="checkbox"/> None | <input type="checkbox"/> 3 – 5 cups |
| | <input type="checkbox"/> 1 – 2 cups | <input type="checkbox"/> 6 cups or more |
| ----- | | |
| 3. When do you usually drink your last cup of caffeinated beverage each day? | <input type="checkbox"/> Before noon | <input type="checkbox"/> Before 8:00 pm |
| | <input type="checkbox"/> Before 4:00 pm | <input type="checkbox"/> Within one hour of bedtime |
| ----- | | |
| 4. Do you smoke cigarettes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If yes, how many packs do you smoke per day? | <input type="checkbox"/> Less than 1/2 a pack | <input type="checkbox"/> 1 pack |
| | <input type="checkbox"/> 1/2 a pack | <input type="checkbox"/> 2 packs or more |
| ----- | | |
| 5. How many alcoholic beverages do you have each week on average? | <input type="checkbox"/> None | <input type="checkbox"/> 8 – 14 drinks |
| | <input type="checkbox"/> 1 – 7 drinks | <input type="checkbox"/> 15 drinks or more |
| ----- | | |
| 6. How many days per week do you exercise 30 minutes or more? | <input type="checkbox"/> 0 days | <input type="checkbox"/> 3 – 4 days |
| | <input type="checkbox"/> 1 – 2 days | <input type="checkbox"/> 5 – 7 days |

SLEEP HABITS

- | | <u>Work Day</u> | <u>Non-Work Day</u> |
|---|---|---|
| 1. What time do you get into bed? | _____ <input type="checkbox"/> am <input type="checkbox"/> pm | _____ <input type="checkbox"/> am <input type="checkbox"/> pm |
| 2. What time do you turn off the lights to go to sleep? | _____ <input type="checkbox"/> am <input type="checkbox"/> pm | _____ <input type="checkbox"/> am <input type="checkbox"/> pm |
| 3. What time do you get out of bed to start the day? | _____ <input type="checkbox"/> am <input type="checkbox"/> pm | _____ <input type="checkbox"/> am <input type="checkbox"/> pm |
| 4. How many hours do you actually spend in bed? | _____ | _____ |
| 5. How many hours do you think you actually sleep? | _____ | _____ |

SLEEP HABITS

6. How many days per week do you nap?

0 days

3 – 6 days

1 – 2 days

Daily

a. If you do nap, for how long?

_____ hours

_____ minutes

7. Do you have a bed partner who can observe your sleep?

Regularly

Rarely

Sometimes

Never

PREPARING FOR SLEEP (please answer the following questions with respect to the last 30 days)

1. On average, how long does it take you to fall asleep at night?

Less than 5 minutes

1 – 2 hours

5 – 30 minutes

More than 2 hours

30 minutes – 1 hour

2. If it takes you more than 30 minutes to fall asleep, please indicate when this started:

Less than 3 months ago

Following a specific event that occurred _____ months / years ago

3 months to 1 year ago

More than 1 year ago

3. How often do you use medication or alcohol to help you fall asleep?

Never

1 – 2 times/week

3 – 5 times/week

Every night

1 – 2 times/month

a. If you use medication, what type do you use? _____

4. Do you have a strong urge to move your legs while sitting or lying down? If yes, please answer the following 5 questions:

Yes

No

a. Is this sensation worse when you are sitting or lying down than when you are moving around or walking?

Yes

No

b. Does this sensation improve if you get up, stretch your legs, or walk?

Yes

No

c. Is this sensation worse in the evening/night than in the morning/afternoon?

Yes

No

d. How often does this sensation occur?

2 – 4 times per month

4 – 5 times per week

2 – 3 times per week

6 – 7 times per week

e. Does this sensation interfere with your sleep?

Yes

No

5. Which of the following do you notice when you try to fall asleep?

Always

Often

Rarely

Never

a. Anxiety, worry, or disturbing thoughts

b. Difficulty breathing or feeling suffocated

c. Pain

d. See and/or hear things that do not really exist

DURING SLEEP

	<u>Frequently</u>	<u>Occasionally</u>	<u>Never</u>	<u>Don't Know</u>
1. Has anyone ever told you that you:				
a. Snore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Stop breathing or wake up gasping for air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Grind your teeth during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sleepwalk, wake up screaming, or eat while asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Kick or twitch your legs during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Act out your dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Frequently</u>	<u>Occasionally</u>	<u>Never</u>	<u>Don't Know</u>
2. How often do you wake up in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. If you wake up, what awakens you? _____

4. What do you do when you are awake? _____

5. How long do you stay awake when you awaken? _____

AWAKE

	<u>Always</u>	<u>Often</u>	<u>Rarely</u>	<u>Never</u>
1. How do you feel when you wake up in the morning?				
a. Tired (want to continue sleeping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Suffer from pains or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Unpleasantly dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Always</u>	<u>Often</u>	<u>Rarely</u>	<u>Never</u>
2. How often does your sleep problem interfere with your work/home functioning (daily chores, concentration, memory, driving, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. As a result of sleepiness, have you experienced any of the following:

<input type="checkbox"/> Auto accident	<input type="checkbox"/> Reduction in quality of life
<input type="checkbox"/> Poor work performance or work related injury	<input type="checkbox"/> None of these

4. Have you ever been paralyzed (unable to move all of your muscles) for a short time when you first awaken? Yes No

5. When you are laughing, surprised or angry, do your muscles become weak (jaw drooping, leg buckling, or falling down)? Yes No

AWAKE

6. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Choose the most appropriate answer for each situation.	High Chance of Dozing	Moderate Chance of Dozing	Slight Chance of Dozing	Would Never Doze
a. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sitting inactive in a public place (theater, meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. In a car while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH

- | | | |
|--|--|--|
| 1. Which of these sleep disorders have you ever been diagnosed with or treated for? (please check all that apply) | <input type="checkbox"/> Obstructive Sleep Apnea
<input type="checkbox"/> Central Sleep Apnea
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Restless Legs Syndrome
<input type="checkbox"/> Periodic Limb Movement Disorder
<input type="checkbox"/> Other: _____ |
| 2. If you've had sleep apnea treatment, what sort of treatment did you have? (please check all that apply) | <input type="checkbox"/> CPAP
<input type="checkbox"/> Surgery | <input type="checkbox"/> Dental Appliance |
| 3. Have any of your immediate family members (blood relatives) been diagnosed or treated for any of these sleep disorders? (please check all that apply) | <input type="checkbox"/> Obstructive Sleep Apnea
<input type="checkbox"/> Central Sleep Apnea
<input type="checkbox"/> Insomnia | <input type="checkbox"/> Narcolepsy
<input type="checkbox"/> Restless Legs Syndrome
<input type="checkbox"/> Periodic Limb Movement Disorder |
| 4. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. In the past two weeks, have you been less interested in most things, or less able to enjoy the things you used to enjoy most of the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever experienced, or witnessed, or had to deal with an extremely traumatic event that included actual or threatened death, or serious injury to you or someone else? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If yes, have you re-experienced this event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions) during the past month? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you worried excessively or been anxious about several things over the past 6 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

