Your Hospital's Logo Here

SLEEP DISORDERS INSTITUTE
HOSPITAL: DePaul Building
Street Address
City, State Zip
Tel: (202) 555 - 1212
Fax: (202) 555 - 1212

SLEEP QUESTIONNAIRE

PATIENT NAME:		M.R. #:		ACCT #:	
STREET ADDRESS:					
CITY:		STATE:		ZIP CODE:	
HOME TEL:	WORK TEL:		AGE:	D.O.B.:	
OCCUPATION:	HEIGHT:	WEIGHT:	NECK SIZE:	GENDER ☐ M ☐ F	
EMERGENCY CONTACT:		RELATIONSHIP:		TEL:	
REFERRING PHYSICIAN:				TEL:	
REFERRING PHYSICIAN ADDRESS:					
CITY:		STATE:		ZIP CODE:	

MAIN SLEEP COMPLAINT QUESTIONS

WHY ARE YOU HERE TO SEE A SLEEP SPECIALIST?

AGE AT WHICH THIS PROBLEM BEGAN:

HOW DOES THIS AFFECT YOUR LIFE & DAILY ACTIVITIES?

HAVE YOU SEEN ANYONE BEFORE FOR THIS -OR- OTHER SLEEP PROBLEMS?

☐ NO ☐ YES ** > >

** IF "YES", DESCRIBE:

PRE-SLEEP ACTIVITY QUESTIONS

WITHIN 4 (FOUR) HOURS OF YOUR BEDTIME, DO YOU . . . .

	YES	NO	NOTES
EAT FATTY / SPICY FOODS ?	☐	☐	
DRINK COFFEE / TEA ?	☐	☐	
SMOKE ?	☐	☐	
DRINK ALCOHOL ?	☐	☐	
EXERCISE ?	☐	☐	
TAKE SLEEPING PILLS ?	☐	☐	
WATCH TELEVISION / READ IN BED ?	☐	☐	

PART OF THE MEDICAL RECORD

BEDTIME QUESTIONS

WHAT TIME DO YOU GO TO BED DURING WEEK DAYS / WORKING DAYS?	WHAT TIME DO YOU AWAKE DURING WEEK DAYS / WORKING DAYS?
WHAT TIME DO YOU GO TO BED DURING WEEK ENDS / OFF DAYS?	WHAT TIME DO YOU AWAKE DURING WEEK ENDS / OFF DAYS?

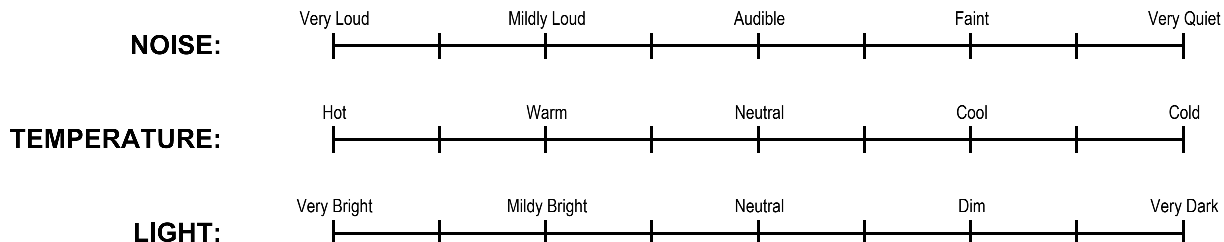
HOW OFTEN DO YOU WAKE UP AFTER FALLING ASLEEP DURING THE NIGHT?

WHY DO YOU WAKE UP DURING THE NIGHT?

WHY DO YOU WAKE UP DURING THE NIGHT?

DO YOU FALL ASLEEP AGAIN EASILY AFTER WAKING UP AT NIGHT?

RATE (WITH AN "X" AT APPROPRIATE PLACE ON BAR GRAPH) YOUR BEDROOM ENVIRONMENT?



SLEEP QUESTIONS

	YES	NO	NOTES
DO YOU SNORE ?	☐	☐	
IF YOU SNORE, IS IT LOUD ?	☐	☐	
IS IT WORSENING ?	☐	☐	
DO YOU WAKE UP GASPING FOR AIR / CHOKING AT NIGHT ?	☐	☐	
HAS ANYONE NOTICED YOU STOP BREATHING WHILE ASLEEP ?	☐	☐	
DO YOU HAVE DIFFICULTY BREATHING AT NIGHT ? If "YES", Describe: ______	☐	☐	
DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE AT NIGHT ?	☐	☐	
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING SENSATIONS IN YOUR LEGS ?	☐	☐	

Restless ____ Nervous ____ Creeping-Crawling Feeling ____ Twitching ____

	YES	NO	NOTES
DO ANY OF THESE LEG SENSATIONS KEEP YOU AWAKE AT NIGHT ?	☐	☐	

HOW DO YOU RELIEVE THESE LEG SENSATIONS ?
Describe: ______

PART OF THE MEDICAL RECORD

SLEEP QUESTIONS (Continued)

	YES	NO	NOTES
HAS ANYONE EVER TOLD YOU YOUR ARMS / LEGS TWITCH WHILE ASLEEP ?	☐	☐	
HAVE YOU EVER FELT PARALYZED WHEN YOU FIRST AWAKE OR WHEN YOU ARE FALLING ASLEEP ?	☐	☐	
HAVE YOU EVER EXPERIENCED FRIGHTENING THINGS, NOISES OR VOICES THAT WEREN'T REAL WHEN :			
YOU WERE ASLEEP ?	☐	☐	
DURING THE NIGHT ?	☐	☐	
AWAKENING FROM SLEEP ?	☐	☐	
DURING THE DAY ?	☐	☐	
DO YOU TALK WHILE ASLEEP ?	☐	☐	
DO YOU WALK WHILE ASLEEP ?	☐	☐	
DO YOU EAT WHILE ASLEEP ?	☐	☐	
DO YOU GRIT YOUR TEETH WHILE ASLEEP ?	☐	☐	
DO YOU HAVE BAD DREAMS WHILE ASLEEP ?	☐	☐	
DO YOU HAVE UNUSUAL MOVEMENT WHILE ASLEEP ?	☐	☐	
DO YOU WAKE UP SCREAMING OR AFRAID FOR NO REASON ?	☐	☐	
DO YOU WAKE UP AT NIGHT WITH A SEVERE HEADACHE ?	☐	☐	
DO YOU WAKE UP FEELING CONFUSED ?	☐	☐	
DO YOU FEEL ACID STOMACH WHILE ASLEEP ?	☐	☐	
DO YOU WAKE UP AT NIGHT HUNGRY OR TO EAT ?	☐	☐	
HAVE YOU EVER ACCIDENTALLY URINATED IN BED ?	☐	☐	
HAVE YOU EVER HAD A SEIZURE WHILE ASLEEP ?	☐	☐	
DO YOU FEEL YOU GET TOO MUCH SLEEP AT NIGHT ?	☐	☐	
DO YOU FEEL YOU GET TOO LITTLE SLEEP AT NIGHT ?	☐	☐	

HOW OFTEN DO YOU USE THE BATHROOM AT NIGHT ? ____________________

POST SLEEP QUESTIONS

	YES	NO	NOTES
DO YOU WAKE UP REFRESHED IN THE MORNING ?	☐	☐	
DO YOU WAKE UP WITH DRY MOUTH / SORE THROAT ?	☐	☐	
DO YOU WAKE UP WITH A HEADACHE ?	☐	☐	
DO YOU WAKE UP WITH CONGESTION ?	☐	☐	
DO YOU WAKE UP ALARMED ?	☐	☐	
DO YOU USUALLY FEEL FATIGUED DURING THE DAY ?	☐	☐	

POST SLEEP QUESTIONS (Continued)

	YES	NO	NOTES
DO YOU USUALLY FEEL SLEEPY DURING THE DAY ?	☐	☐	
DO YOU FIND YOURSELF FALLING ASLEEP WHEN YOU DON'T WANT TO ?	☐	☐	
HAS FALLING ASLEEP EVER PUT YOU OR SOMEONE ELSE IN DANGER ?	☐	☐	
HAVE YOU EVER HAD AN ACCIDENT RELATED TO SLEEPINESS ?	☐	☐	
HAVE YOU EVER HAD A CLOSE CALL OR ACCIDENT WHEN DRIVING DUE TO SLEEPINESS ?	☐	☐	
DO YOU FEEL DROWSY / SLEEPY WHEN DRIVING ?	☐	☐	
DO YOU SUFFER FROM MEMORY PROBLEMS ?	☐	☐	
ARE YOU MORE IRRITABLE LATELY ?	☐	☐	
DO YOU TAKE ANY DAYTIME NAPS ?	☐	☐	
HOW MANY NAPS PER WEEK ?			
HOW LONG DO NAPS TYPICALLY LAST ?			
DO YOU DREAM DURING NAPS ?	☐	☐	
ARE THE NAPS REFRESHING ?	☐	☐	
HAVE YOU EVER EXPERIENCED SUDDEN BODILY WEAKNESS OR PARALYSIS ON ANY PART OF YOUR BODY IN RESPONSE TO AN EMOTIONAL STATE ?	☐	☐	
HAVE YOU EVER HAD A FIT / SEIZURE IN THE DAY ?	☐	☐	

EPWORTH SLEEPINESS SCORE

USE THE FOLLOWING SCALE:

0 = WOULD NEVER DOZE

1 = SLIGHT CHANCE OF DOZING

2 = MODERATE CHANCE OF DOZING

3 = HIGH CHANCE OF DOZING

...TO RATE HOW LIKELY YOU ARE TO DOZE OFF / FALL ASLEEP IN THE FOLLOWING SITUATIONS:

________ SITTING AND READING

________ WATCHING TELEVISION

________ SITTING INACTIVE IN A PUBLIC PLACE

________ WHILE A PASSENGER IN A CARE WITHOUT A BREAK

________ LAYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT

________ SITTING AND TALKING TO SOMEONE

________ SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL

________ IN A CAR, WHILE STOPPED IN TRAFFIC FOR A FEW MINUTES

PART OF THE MEDICAL RECORD

HISTORY QUESTIONS

MEDICAL HISTORY: LIST ALL PREVIOUS AND CURRENT MEDICAL PROBLEMS YOU'VE EVER BEEN DIAGNOSED / TREATED FOR:

SURGICAL HISTORY: LIST ALL OPERATIONS OR INJURIES YOU'VE BEEN TREATED FOR. INCLUDE CHILDHOOD SURGERIES.

PSYCHIATRIC / MENTAL HEALTH HISTORY: LIST ALL PSYCHIATRIC / MENTAL HEALTH PROBLEMS. INCLUDE ANXIETY & DRUG DEPENDENCE PROBLEMS.

MEDICATIONS: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

FAMILY HISTORY: LIST ALL MEDICAL, PSYCHIATRIC & SLEEP PROBLEMS IN YOUR CLOSE FAMILY MEMBERS.

PART OF THE MEDICAL RECORD

GENERAL QUESTIONS

	YES	NO	Describe
DO YOU DRINK ALCOHOL ?	☐	☐	.... HOW MUCH ?
DO YOU SMOKE TOBACCO ?	☐	☐	.... HOW MUCH ?
DO YOU TAKE CAFFEINE ? (TEA, COFFEE, SODA)	☐	☐	.... HOW MUCH ?
DO YOU USE ILLEGAL DRUGS ?	☐	☐	.... WHAT TYPE ?
DO YOU HAVE ANY ALLERGIES ?	☐	☐	.... WHAT TYPE ?
DO YOU HAVE ANY MEDICATION ALLERGIES ?	☐	☐	.... WHAT TYPE ?
WHAT IS YOUR USUAL WORK SCHEDULE ?	START SHIFT: ---------------- ☐ AM ☐ PM		END SHIFT: ---------------- ☐ AM ☐ PM
DO YOU WORK EXTENDED OR ROTATING SHIFTS ?	☐	☐	.... HOW OFTEN ? .... WHAT HOURS?
ANY RECENT WEIGHT GAIN ?	☐	☐	.... AMOUNT / TIMEFRAME
HAVE YOU BEEN IN A WEIGHT CONTROL PROGRAM ?	☐	☐	.... DESCRIBE
HAVE YOU HAD ANY SURGERY TO LOOSE WEIGHT ?	☐	☐	.... WHEN ?

ADDITIONAL COMMENTS

PLEASE USE THE SPACE BELOW TO PROVIDE ADDITIONAL SLEEP OR MEDICAL HISTORY NOT MENTIONED ABOVE:

PART OF THE MEDICAL RECORD