

## SLEEP QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: M/F      Height \_\_\_\_\_      Weight \_\_\_\_\_      Neck size \_\_\_\_\_

### Check all that apply:

- I snore or have been told I snore
- I have been told I stop breathing during sleep
- I wake up choking, gasping, or short of breath
- I wake myself up with my snoring
- I am sleepy during the day
- I am fatigued throughout the day
- I fall asleep unintentionally during the day
- I have memory loss
- I have problems with concentration
- I am a restless sleeper
- I kick my legs at night
- I have restless legs syndrome
- I have insomnia

How long have you had symptoms that you know of? \_\_\_\_\_

How does this affect your life and daily activities? \_\_\_\_\_

What time do you typically go to bed and get up?

Weekdays BEDTIME \_\_\_\_\_ am/pm      WAKE Time \_\_\_\_\_ am/pm

Weekends BEDTIME \_\_\_\_\_ am/pm      WAKE Time \_\_\_\_\_ am/pm

On average, how long do you actually sleep at night? \_\_\_\_\_ hrs \_\_\_\_\_ mins

### MEDICAL HISTORY

- |   |  |
|---|--|
| <input type="checkbox"/> Hypertension                   | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Depression/anxiety        |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Thyroid problems          |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> Kidney problems           |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Anemia                    |
| <input type="checkbox"/> Reflux                         | <input type="checkbox"/> Prostate problems         |
| <input type="checkbox"/> Stroke/TIA's                   | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Migraine headaches             | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Hepatitis B or C               | <input type="checkbox"/> Other blood-borne disease |
| <input type="checkbox"/> Other (please describe: _____) |  |

**ALLERGIES (include latex or tape)** \_\_\_\_\_

**Please list your current medications**

\_\_\_\_\_

\_\_\_\_\_

**RESTLESSNESS**

- I am a restless sleeper
- I kick or jerk my legs and/or arms during sleep
- I have restlessness, tingling or crawling sensation in my legs or arms
- I am unable to keep my legs still prior to falling to sleep
- I grind my teeth in my sleep

**OTHER COMPLAINTS**

- When falling asleep or waking up, I sometimes feel paralyzed (unable to move)
- At night my heart pounds, beats rapidly or beats irregularly
- I have a lot of nightmares
- I sleepwalk
- I have seen or heard things that weren't real when waking up or going to sleep
- I get sudden weakness or feel like I will fall when I laugh or get angry

**Other questions**

- Do you have a regular bed partner? Y / N
- On average, how long does it take you to fall asleep at night after you turn out your bedroom lights? \_\_\_\_\_ minutes
- What do you usually do just before turning out the lights and trying to go to sleep (read, watch TV, bath, etc) \_\_\_\_\_
- On average, how often do you wake up during the night? \_\_\_\_\_
- Do you wake up too early, unable to go back to sleep? Y / N
- Do you usually awaken to an alarm or spontaneously on your own? \_\_\_\_\_
- Do you nap or go back to bed after getting up? Y / N If so, how many times per day? \_\_\_\_
- Average length of nap? \_\_\_\_\_ Do you feel more refreshed after the nap? Y / N
- Are you bothered by sleepiness during the day? Y / N
- Do you feel that you get too much sleep at night? Y / N
- Do you feel that you get too little sleep at night? Y / N
- Do you usually feel tired during the day? Y / N
- If so, why do you think this is so? \_\_\_\_\_

**SOCIAL HISTORY**

- Do you smoke? \_\_\_\_ How much? \_\_\_\_ When did you quit? \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_ How often? \_\_\_\_\_
- Do you drink caffeine? \_\_\_\_ How often? \_\_\_\_\_
- Do you use marijuana or other non-prescription drugs? If so, what? \_\_\_\_\_
- I am a shift worker on rotating shifts
- I am a permanent or long term night shift worker

## FAMILY HISTORY

Is there any one in your family with a sleep problem? If so, please describe:

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## Epworth Sleepiness Scale

Use this scale to choose the most appropriate number for each situation

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Sitting and reading \_\_\_\_\_

Watching TV \_\_\_\_\_

Sitting in a public place for example, a theatre or meeting \_\_\_\_\_

As a passenger in a car for an hour without a break \_\_\_\_\_

Lying down to rest in the afternoon \_\_\_\_\_

Sitting and talking to someone \_\_\_\_\_

Sitting quietly after lunch (when you have had no alcohol) \_\_\_\_\_

In a car, while stopped in traffic \_\_\_\_\_

Total: \_\_\_\_\_

Please check all that apply:

\_\_\_ I take daytime naps

\_\_\_ I have had auto accidents as a result of falling asleep while driving

\_\_\_ I fight to stay awake while driving

\_\_\_ I have had injuries as a result of falling asleep in the daytime

\_\_\_ Daytime sleepiness is affecting my job or quality of life

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Please notify us of the best way we can reach you:

Home Phone#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Other Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

I authorize the St. Joseph Sleep Disorders Lab and/or Pulmonary and Critical Care Associates' sleep coordinator to leave results via my phone or email address provided.

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Signature

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Date