

## 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!**



### CONFIDENTIAL SLEEP QUESTIONNAIRE

**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:
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____
_____	_____	_____ <u>am / pm</u>	_____

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.



**CONFIDENTIAL SLEEP QUESTIONNAIRE**

**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? \_\_\_\_\_*



**CONFIDENTIAL SLEEP QUESTIONNAIRE**

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



### CONFIDENTIAL SLEEP QUESTIONNAIRE

## 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: \_\_\_\_\_



### CONFIDENTIAL SLEEP QUESTIONNAIRE

**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**CONFIDENTIAL SLEEP QUESTIONNAIRE**