Memorial Premier Sleep Center

SLEEP QUESTIONNAIRE

Name: _____ Date: _____ Location: _____

Referring Physician: _____ Primary Physician: _____

Height: ___ ft. ___ in. Weight: _____ lbs. Neck size: _____ DOB: _____ Age: _____ Sex: _____

Occupation: _____ Usual Work Hours/Days _____

Please circle marital status: Single Married Divorced Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in the appropriate areas.

Chief Complaint

Unwanted behaviors during the night? Please explain: _____

Other, explain: _____

_____

Sleep Patterns

	Work Days(Weekday)	Off Days(Weekends)
Typical Bedtime		
Typical amount of time it takes to fall asleep?		
List any awakenings due to i.e., restroom, eating, watching TV etc.?		
Typical amount of time to fall back asleep after awakening?		
Typical wake up time?		
How many times do you wake up in the night?		
How do you usually awaken, i.e. alarm clock?		

Current Medications

_____ _____

_____ _____

_____ _____

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Habits

Do you smoke? (circle) Yes No

If Yes:	What?	Amount per Day	For How Many Years
	Cigarettes	_____ pack(s)	_____ years
	Cigars	_____ cigar(s)	_____ years
	Tobacco	_____ pipes	_____ years

Do you drink alcohol? (circle) Yes No

If Yes:	What?	Frequency (circle)	Amount per Week
	Beer	Daily Weekends Rare	_____ cans/week
	Wine	Daily Weekends Rare	_____ glasses/week
	Liquor	Daily Weekends Rare	_____ shots/week

Do you drink caffeine? (circle) Yes No

If Yes:	What?	Frequency (circle)	Amount per Week
	Soda	Daily Weekends Rare	_____ cans/week
	Tea	Daily Weekends Rare	_____ glasses/week
	Chocolate	Daily Weekends Rare	_____ bars/week
	Coffee	Daily Weekends Rare	_____ cups/week

Past Sleep Evaluation and Treatment

- ☐ I have had a previous sleep disorder evaluation
- ☐ I have had a previous overnight sleep study
- ☐ I have had a daytime nap study
- ☐ I have been prescribed a CPAP or bi-level PAP machine for home use
- ☐ I have had surgical treatment for a sleep disorder
- ☐ I have previously been prescribed medication for a sleep disorder
- ☐ I have previously been treated for a sleep disorder

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Sleep History/Habits

	witnessed snoring		fatigued		pain during the night
	witnessed apnea		lack energy		sleep walking
	perception of choking		trouble initiating sleep		short of temper
	excessive daytime sleepiness		trouble staying asleep		grinding teeth
	non refreshed sleep		trouble concentrating		night sweats
	leg kicks/jerks		restless/disturbed sleep		vivid dreams
	restless legs		shift worker		cataplexy
	Drink alcohol before bedtime		racing thoughts		fall asleep driving
	watch TV in bed		daytime naps		hallucinations

Medical History

	high blood pressure		hemophilia		impotence
	low blood pressure		diabetes		headaches
	heart disease		obesity		fainting
	heart attack		anxiety		dizziness
	bypass surgery		depression		seizures
	pacemaker		psychiatric problems		hiatal hernia
	stroke		allergies		reflux
	COPD (emphysema/Bronchitis)		tonsillectomy		heartburn
	asthma		sinus problems		ulcers
	high cholesterol		nose fracture		GERD
	arthritis		nasal surgery		fibromyalgia
	eye trouble		muscle cramps/weakness		cancer
	hearing trouble		kidney trouble		meningitis
	tuberculosis		prostate trouble		Chronic pain
	menopause		premenstrual syndrome		hepatitis
	thyroid problems		“black outs”		Other:

Please list all surgeries below:

_____

_____

_____