



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

	<u>Work Days(Weekday)</u>	<u>Off Days(Weekends)</u>
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



Memorial Premier Sleep Center

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

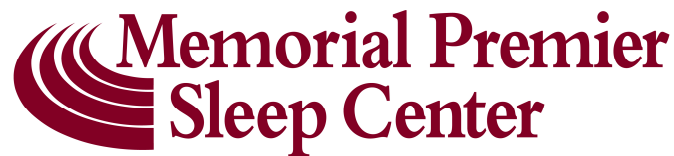
Coffee

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



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:
