Better Sleep Labs

Institute of Sleep Medicine

Sleep Questionnaire

Please answer the following questions as completely as possible. You may confer with your spouse, bed-partner or roommate to help answer as accurately as possible.

Name: _____Date of birth: _____

Requesting physician: _____

Date of office visit: _____

Main complaint: _____

CHIEF COMPLAINT

How would you describe your sleep difficulties? (Please circle appropriate items)

A. Difficulty falling asleep
B. Difficulty staying asleep
C. Nightmares / unusual sleep
D. Sleep Walking
E. Snoring
F. Waking up too early
G. Difficulty staying awake during the daytime
H. Unusual movements in sleep
I. Unrefreshed sleep
J. Bed Wetting
K. Sleepiness while driving

SLEEP / DAY SCHEDULE

1. What is your usual bedtime? _____ Get up time? _____
2. Approximately how many hours do you sleep each night? _____
3. How long does it take you to fall asleep? _____
4. Approximately how many times do you wake up each night? _____
5. How long is your longest wake time? _____
6. Do you go back to sleep easily after waking in the middle of the night? _____
7. What are your work hours? _____
8. Do you work night shift hours? _____

SYMPTOMS

1. Is your bed partner disturbed by your sleep problem? YES _____ NO _____ Does not apply _____

2. Do you feel drowsy or sleepy in these situations?: (please circle appropriate item(s)

   A. Eating Meals
   B Watching Television
   C. Talking in a group
   D. Reading
   E. Driving
   F. In church, watching a movie or play

3. Does daytime sleepiness interfere with your ability to function normally? YES _____ NO _____

4. Have you been involved in an automobile accident because of sleepiness while driving? YES_____ NO_____

5. Do you take naps? YES_____ NO _____ SOMETIMES _____

6. Do you snore? YES _____ NO _____

7. Have you been told that you do any of the following while sleeping?

   A. Stop breathing while sleeping
   B. Wake from sleep snorting or choking
   C. Walk in your sleep
   D. Grind your teeth

8. Do you wake up in the morning with dry mouth or headaches? YES _____ NO _____

9. Do you feel fresh in the morning when you wake up? YES _____ NO _____

10. Do you have any problems with sexual functioning? YES _____ NO _____

11. Do you experience vivid dream like images while falling asleep or awakening from naps? YES ____ NO _____

12. Do you dream during naps? YES _____ NO _____

13. Have you ever felt paralyzed while falling asleep or awakening form nap? YES _____ NO _____

14. Have you ever had a feeling of weak knees when you laugh? YES _____ NO _____

15. Do you experience creeping, crawling, or aching sensations in your legs, or an inability to keep your legs still?

    YES _____ NO _____

    If so, does it keep you from falling asleep? YES _____ NO _____

16. Do you watch a clock, watch television, have racing thoughts, or worry about the next day at the time of falling asleep? YES_____ NO _____

17. Do you exercise before going to sleep? YES_____ NO _____

18. What is your weight now? _____ 6 months ago_____ 2 years ago _____

MEDICAL HISTORY

1. Do you have…… (Please circle)

A. High Blood Pressure
B. Diabetes
C. Asthma / Emphysema
D. Epilepsy / Seizures / Stroke
E. Heart Attack / open heart surgery
F. Cancer If so, where is or where was the cancer _____

2. Do you have any other medical problems? _____

SOCIAL HISTORY

1. How much of these beverages do you drink on a daily basis? (Please circle)

A. Coffee 1 2 3 4 5 6+
B. Beer 1 2 3 4 5 6+
C. Liquor 1 2 3 4 5 6+
D. Tea 1 2 3 4 5 6+
E. Wine 1 2 3 4 5 6+
F. Soft Drinks – caffeinated / caffeine free
1 2 3 4 5 6+

2. Do you smoke on a regular basis? YES_____ NO _____

If so, how long have you smoked? _____ How many per day? _____

MEDICATION HISTORY

1. Do you take any medications including over the counter mediations to help you fall asleep or stay awake?

YES_____ NO _____ if so, list the medication(s) you are using _____

_____

Please list your current medications ***(unless you have a list with you)***

_____

_____

This information is needed to better serve you and to help make you more comfortable during testing. Please indicate any that apply.

FUNCTIONAL LIMITATIONS

_____None
_____ Amputation
_____ Paralysis
_____ Bed Confined
_____ Use of crutches
_____ Wheelchair
_____ Assist to Ambulate
_____Claustrophobia
_____ Facial or Hand Deformities
_____ Arthritis
_____ Hearing impaired
_____ Use of cane
_____ Speech impaired
_____ Use of walker
_____ Ambulation impaired
_____ Vision impaired