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Sleep Questionnaire for Adults

The information you are being asked to provide is VERY important and will assist us during your visit to the Sleep Clinic. Please respond to all questions. The information will be treated with the utmost discretion and will not be used by any party other than the Sleep Disorders Center.

Note- if you don't know the answer, please write "I don't know". If the question does not apply to you please write "N/A", do not leave it blank. Let us know if you need help with any question.

Patient Name: _____
Gender: Male ☐ **Female** ☐
Patient Address: _____
Patient Phone Number:_____
DOB: _____
Clinic Visit Date:_____
Referring Physician: _____
Physician Contact Number: _____

SLEEP PROBLEMS (please check all that apply)

☐ **Snoring**
☐ **Difficulty falling asleep**
☐ **Difficulty staying asleep**
☐ **Morning Headache**
☐ **Other** _____
☐ **Gasping/ Choking / repeated pauses in breathing with sleeping**
☐ **Unusual behavior in sleep (walking, talking, acting out dreams)**
☐ **Tired/Sleepy during the day**
☐ **Unrefreshing Sleep**

HEIGHT AND WEIGHT

What is (was) your body weight

Now	_____	**pounds**
6 months ago	_____	**pounds**
At age 20	_____	**pounds**
At heaviest	_____	**pounds**

What is your height _____**feet** _____**inches**

Problems when trying to go to sleep:

_____ **Anxiety**
_____ **Feels afraid of not being able to sleep**
_____ **Feels afraid of the dark or anything else**
_____ **Feels muscular tension**
_____ **Feels sad or depressed**
_____ **Feels unable to move**
_____ **Has creeping, crawling, aching or twitching feeling in your legs**
_____ **Has pain or discomfort**
_____ **Sudden unexplainable alertness while trying to fall asleep**
_____ **Thoughts racing through the mind**
_____ **Vivid, dream-like scenes when between sleep and wakefulness**

…Please answer with one of the following numbers…

0. Never
1. Rare
2. Infrequent
3. Occasional
4. Frequent
5. Constant

Problems while sleeping:

_____ **Acts out dreams**
_____ **Arms or legs twitch or jerk while asleep**
_____ **Bed wetting**
_____ **Bruxism (grinding or clinch teeth when sleeping)**
_____ **Dreams that are so real they do not seem like the patient is asleep**
_____ **Falls out of bed when asleep**
_____ **Heart pounding during the night**
_____ **Night sweats**
_____ **Night terrors**
_____ **Nightmares**
_____ **Restless, disturbed sleep**
_____ **Sleep walking**
_____ **Snoring**
_____ **Strange dreams**
_____ **Talking in sleep**
_____ **Unusual movement while asleep**
_____ **Waking up short of breath during the night**

Problems associated with waking up:

_____ **Confusion and disorientation on awakening**
_____ **Difficulty waking up**
_____ **Dream-like images on awakening**
_____ **Dry mouth on awakening**
_____ **Feels unable to move when waking up**
_____ **Has to use an alarm clock to wake up**
_____ **Headache on awakening**
_____ **Nausea on awakening**
_____ **Oversleeps often**

Excessive daytime sleepiness:

_____ **Decreased concentration or memory problems due to sleepiness**
_____ **Falls asleep in inappropriate circumstances**
_____ **Falls asleep or fights sleep while driving**
_____ **Falls asleep unintentionally or fights to sleep at work**

SLEEP HABITS

1. How many days per week do you nap? ☐ 0 days ☐ 3-6 days ☐ 1-2 days ☐ every day

1a. If you do nap, for how long? _____hours _____ minutes

2. How would you describe your sleep habits? ☐ Morning person ☐ Night Owl

	Work Day	Non-work day
3. What time do you get into bed?	_____☐am ☐pm	_____☐am ☐pm
4. What time do you turn off the lights to go to sleep?	_____☐am ☐pm	_____☐am ☐pm
5. What time do you get out of bed to start the day?	_____☐am ☐pm	_____☐am ☐pm

6. Consistency of sleep schedule.

☐ Very consistent (6 to 7 nights are the same) ☐ Consistent (5 to 7 nights are the same)
☐ Somewhat consistent (3 to 5 nights are the same) ☐ Not consistent (2 to 3 nights are the same)
☐ Inconsistent (every night during the week is different)

7. Do you have a bed partner who can observe you sleep? ☐yes ☐no

8. On average, how long does it take you to fall asleep?

☐ Frequently ☐ Occasionally ☐ Infrequently ☐ Rarely
☐ 5 minutes or less ☐ 1-2 hours ☐ 5-30 minutes ☐ more than 2 hours ☐ 30 minutes-1 hour

9. How many hours do you think you actually sleep? _____ Non-work day _____ Work Day

10. How often do you wake up during the night? _____

10a. If you wake up, what wakes you? _____

10b. What do you do when you're awake? _____

10c. How long do you stay awake? _____

11. Please describe your predominant work schedule. ☐ Day shift (9-5) ☐ Evening shift (3-11) ☐ Night shift (11-7) ☐ Variable schedule ☐ Unemployed / retired

12. Duration of sleep problem? (weeks, months, years, etc.) _____

13. How often do you use a sleep aid (prescribed medication or over the counter) or alcohol to help you fall asleep?

☐ never ☐ 3-5 times/week ☐ 1-2 times/ month ☐ every night ☐ 1-2 times/week

What type of sleep aid do you use?_____

****Check if it is concurrent with you****

Predisposing factors:

- ☐ **Alcohol before bed: what kind and how much_____**
- ☐ **Caffeinated beverages or chocolate**
- ☐ **Family history or anxiety/panic disorder**
- ☐ **Family history of obesity**
- ☐ **Family history of snoring, excessive daytime sleepiness**
- ☐ **Food or meal within a few hours of bedtime---how many hours? _____**
- ☐ **History of concussion**
- ☐ **Nose or sinus issues**
  - ☐ **Allergy** ☐ **Chronic sinus problems** ☐ **Nasal congestion**
- ☐ **Obesity**
- ☐ **Sedating or stimulant medications and recreational drugs such a**
  - ☐ **Antihistamines** ☐ **Nasal decongestant** ☐ **Sleeping pills**
- ☐ **Throat or mouth problems such as**
  - ☐ **Difficulty swallowing** ☐ **Bad breath or foul taste in mouth** ☐ **Sore throat**
- ☐ **Tobacco use? What kind and how much?**

  _____
- ☐ **Tonsil problems**
- ☐ **Total daily caffeinated beverage consumption? What kind and how much?**

  _____

Aggravating Factors:

Environmental problems:

- ☐ **Has to get up frequently to care for children**
- ☐ **Mattress uncomfortable**
- ☐ **Noisy bed partner**
- ☐ **Restless bed partner**
- ☐ **Room to ___cold, ___hot, ___light, ___noisy (mark all that apply)**
- ☐ **Excessive fatigue**
- ☐ **Irregular sleeping schedule**

Medical problems that disturb sleep:

- ☐ **Asthma**
- ☐ **Cough**
- ☐ **Creeping or crawling feelings in the legs**
- ☐ **Dreaming of suffocating or drowning**
- ☐ **Episodes of choking**
- ☐ **Frightening dreams**
- ☐ **Hunger**
- ☐ **Indigestion or heartburn**
- ☐ **Nasal congestion**
- ☐ **Need to urinate**
- ☐ **Pain**
- ☐ **Shortness of breath**
- ☐ **Thirst**
- ☐ **Sedating medication**
- ☐ **Sleeping on the back**
- ☐ **Stress**
- ☐ **Weight gain**

Relieving factors:

- ☐ **Elevate head of bed**
- ☐ **Sleeping on extra pillows**
- ☐ **Sleeping on the side**
- ☐ **Sleeping upright**
- ☐ **Weight loss**

SLEEPINESS INDEX

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how that would have affected you. Choose the most appropriate answer for each situation

	High Chance of dozing	Moderate Chance of dozing	Slight Chance of dozing	Would never doze
a. Sitting and reading	☐	☐	☐	☐
b. Watching TV	☐	☐	☐	☐
c. As a passenger in a car for 1 hour without a break	☐	☐	☐	☐
d. Sitting inactive in a public place (theater, meeting)	☐	☐	☐	☐
e. Lying down to rest in the afternoon when circumstance permit	☐	☐	☐	☐
f. In a car, stopped for a few minutes in traffic	☐	☐	☐	☐
g. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
h. Sitting and talking to someone	☐	☐	☐	☐

SLEEP MEDICAL HISTORY

Note: If you do not know the answer, please write, "I don't know", do not leave blank.

Have you had a previous Sleep Study? Yes ☐ No ☐
If so, when are where?
_____

Which of these sleep disorders have you even been diagnosed with or treated for? (check all that apply)

- ☐ Obstructive sleep apnea
- ☐ Central Sleep Apnea
- ☐ Insomnia
- ☐ Restless legs Syndrome
- ☐ Periodic limb movement disorder
- ☐ Narcolepsy
- ☐ Other: _____

If you have received treatment for sleep apnea, what sort of treatment did you have? (check all that apply)

- ☐ CPAP
- ☐ Surgery
- ☐ Dental appliance
- ☐ Other: _____

If you are on CPAP or Bi-PAP, what is your current pressure? _____

How often do you use CPAP or Bi-PAP?_____

Do you use oxygen at night? Yes ☐ No ☐

HEALTH

Please check all that apply in the boxes beside the medical problems that you have now or have had in the past or write in the empty space provided.

☐ Allergies/nasal congestion/sinusitis	☐ Diabetes	☐ Depression
☐ Asthma	☐ Hyperthyroid	☐ Anxiety disorder
☐ Emphysema/COPD	☐ Hypothyroid	☐ Panic disorder
☐ Congestive heart failure	☐ Arthritis	☐ High cholesterol
☐ Heart valve problems	☐ Kidney disease	☐ Brain injury
☐ Heart disease (angina, heart attack)	☐ Liver disease	☐ Parkinson's disease
☐ Hypertension/High blood pressure	☐ Schizophrenia	☐ Dementia
☐ Irregular heart beat	☐ Stroke	☐ Tonsil and adenoid removal
☐ Atrial fibrillation	☐ Seizures/epilepsy	☐ Heartburn/Acid reflux
☐ Pacemaker	☐ Migraine	
☐ Throat surgery for sleep apnea (UPPP		

Other medical problems (please write them below):

_____
_____
_____
_____

Medications ☐ **I am currently not taking any medications.**
If you are taking medications, please list all of them (prescription or over-the-counter)

List of medications

_____
_____
_____
_____
_____