



ADULT SLEEP QUESTIONNAIRE

Date: _____

Patient's Name: _____ Birth date: _____ Age: _____

Height: _____ Weight: _____ Neck size _____ Sex: M F

Phone Number: () _____ Occupation: _____

Name of Referring Physician(s): _____ Phone: _____

_____ Phone: _____

Reason for referral:

How long have you been bothered by this problem? _____

SLEEP HISTORY

Your Bedtime in Weekdays _____ Weekends and Holidays _____

Your Wake up time on Weekdays _____ Weekends _____

How long it will take you to fall asleep? _____

How much time do you spend in the bed after waking up in the morning? _____

Total sleep time: Night? _____ Naps? _____

About falling asleep: Do you feel or suffer frequently from the following:

Restless sleep? ___ Yes ___ No, difficulty initiating sleep? ___ Yes ___ No

Tingling, creepy, or crawling sensation in your legs at rest? ___ Yes ___ No

The urge to move your legs after that? ___ Yes ___ No

Moving your legs will eliminate this discomfort? ___ Yes ___ No

Feeling unable to move your legs/arms at sleep or wake up time? ___ Yes ___ No

Seeing frightening "dreams" at sleep or wake up time? ___ Yes ___ No

Racing thoughts in your mind? ___ Yes ___ No

Feeling depressed or sad? ___ Yes ___ No

Feeling Anxious? ___ Yes ___ No

Feeling muscular tension? ____ Yes ____ No
Being afraid of dark or anything else? ____ Yes ____ No
Having any kind of pain or discomfort? ____ Yes ____ No

DURING SLEEP:

Do You:

Wake up from sleep? Yes ____ No ____ How often? ____
WHY? _____.

Snore? ____ Y ____ N Loud? ____ Y ____ N
Pause or stop breathing? ____ Y ____ N
Struggle to breathe? ____ Y ____ N
Breathe through your mouth? ____ Y ____ N
Wake up Choking? ____ Y ____ N
Walk in your sleep? ____ Y ____ N
Talk in your sleep? ____ Y ____ N
Wake up screaming, violent or confused? ____ Y ____ N
Kick with your legs? ____ Y ____ N
Have dream like images when waking up? ____ Y ____ N
Have unusual Movements while asleep? ____ Y ____ N
Grind your teeth? ____ Y ____ N

ABOUT WAKING UP:

Do You Wake up:

With headache? ____ Y ____ N
Sleepy? ____ Y ____ N Tired? ____ Y ____ N
With dry mouth? ____ Y ____ N

DURING THE DAY:

Do you:

Feel Unrefreshed when waking up? ____ Y ____ N
Feel sleepy? ____ Y ____ N Feel tired? ____ Y ____ N
Feel sleepy while inactive (Watching TV, Reading, etc.)? ____ Y ____ N
Feel unable to concentrate? ____ Y ____ N
Have difficulty sustaining attention? ____ Y ____ N
Feel Unable to remember things? ____ Y ____ N
Doze off in a meeting? ____ Y ____ N
Doze off driving? ____ Y ____ N
Feel depressed, sad, or irritable? ____ Y ____ N
Feelings of guilt, hopelessness? ____ Y ____ N
Have Decreased or loss of appetite? ____ Y ____ N

Have you ever noticed loss of muscle tone after emotional changes such as:

Fear, anger or excitement? ___ Y ___ N
Do you feel the irresistible urge to sleep? ___ Y ___ N

Any Current Medical Problem? 1- _____ 2- _____
3- _____ 4- _____

Past Medical History: 1- _____ 2- _____
Previous Surgery(s): _____

ANY CURRENT MEDICATIONS/ INHALAR? SPRAYS:

<u>NAME</u>	<u>Time</u>	<u>Reason you take it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the name of any pills for SLEEPING or to help you STAY AWAKE :

<u>Name</u>	<u>Does it help?:</u>
_____	___ Y ___ N
_____	___ Y ___ N
_____	___ Y ___ N

Allergy to medicine: _____

Family History:

Sleep Apnea? ___ Sleep Walking? ___ Sleep Terror? ___ Nightmare? ___
Bed Wetting? ___ Narcolepsy? ___ Seizure? ___ Stroke? ___
Heart attack? ___ High blood pressure? ___ Acid reflux? ___
Hay fever? ___

Personal Habits:

Do you smoke? ___ Y ___ N If yes how many cigarettes/day? ___
Do you drink Alcohol? ___ Y ___ N IF YES; how often? ___
When do you drink? ___
Any recreational drugs? ___ Y ___ N
Do you drink coffee/tea in the afternoon? ___ Y ___ N
How much? ___ What time? ___

Any history of weight change? ___ Gain ___ Loss How much? ___
Over How Long? ___

