



Adult Sleep Questionnaire

DATE: _____

NAME: _____ SEX: _____ AGE _____ DOB _____

DAY PHONE: _____ EVE PHONE: _____ CELL: _____

OCCUPATION: _____ Ht: _____ Wt. _____ NECK SIZE? _____

FAMILY DOCTOR: _____

REFERRING DOCTOR: _____

Please answer the following Questions:

1. Reason (s) for referral/ consult/sleep study:

Sleep Apnea _____ Daytime sleepiness _____ Insomnia _____

Multiple Awakenings from sleep _____ Nightmares _____

Sleepwalking _____ Sleep Terrors _____ Choking at night _____

Others _____

Does this problem happen? [] Every night [] Several times per week

[] Several times per month

How long have you been bothered by this problem?

[] Longer than 2 yrs [] 1 year [] Several months [] Recently

2. What time do you usually try to fall asleep? _____ a.m. _____ p.m.

3. How long does it usually take you to fall asleep? _____ minutes.

4. How often each week does it take more than 30 minutes to fall asleep? _____

5- How many hours of sleep do you get each night on the average _____ ?

6- Do you take naps? _____ When? _____ How long? _____

Are the naps refreshing? _____ Yes _____ No

7. When falling asleep or trying to fall asleep, how often do you have/ feel:

Insomnia/ RLS

	Never	Some	Always
a) thoughts racing through your mind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) sad or depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) anxiety (worry about things) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) muscular tension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) afraid of not being able to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) any kind of pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) creepy, crawly, achy or twitchy feelings in legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) the urge to move your legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) temporary relief of this discomfort by moving your legs ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J) trouble initiating sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) trouble maintaining sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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ABOUT SLEEPING:

8. Do you wake up from sleep? Yes _____ No _____ How often? _____

9. How often do you (**CHECK ONE BOX AFTER EACH STATEMENT**)

	Never	Some	Always
a) have restless, disturbed sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) get up at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) been told that you snore, snort, or gasp loudly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) been told that you stop breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) wake up Choking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) breathe through your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) sweat a lot during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) walk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) fall out of bed while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) wake up screaming, violent or confused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) have unusual movements while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) wet the bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) act your dreams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) grind teeth at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. My sleep is frequently disturbed by:

Choking _____ Indigestion _____ Heat/ cold _____ Noise _____
 Coughing _____ Need to urinate _____ Hunger _____ Thirst _____
 Others _____

ABOUT WAKING UP

11. What time do you usually have your final awakening? _____ a.m./p.m.

12. How long do you lay in bed awake before getting up? _____ minutes

13. How often do you (CHECK ONE BOX FOR EACH STATEMENT)

	Never	Some	Always
a) depend on an alarm to wake up?	[]	[]	[]
b) "sleep in" in the morning (more than one hour past your usual wake-up time) ?	[]	[]	[]
c) have hard time waking up?	[]	[]	[]
d) wake up confused or disoriented?	[]	[]	[]
e) wake up with a headache?	[]	[]	[]
f) wake up nauseous (sick to your stomach)?	[]	[]	[]
g) wake up with dry mouth?	[]	[]	[]
h) wake up 1 or 2 hours before you have to get up?	[]	[]	[]

ABOUT DAYTIME FUNCTIONING:

14. How often do you (CHECK ONE SPACE FOR EACH STATEMENT)

	Never	Some	Always
a) feel sleepy during the day?	[]	[]	[]
b) actually fall asleep while driving?	[]	[]	[]
c) actually fall asleep when at work or at social events?	[]	[]	[]
d) feel sad or depressed?	[]	[]	[]
e) have anxiety (worry about things) ?	[]	[]	[]
f) feel muscular tension?	[]	[]	[]
g) feel unable to concentrate?	[]	[]	[]
h) feel unable to remember things?	[]	[]	[]
i) have difficulty sustaining attention?	[]	[]	[]

15- If you feel sleepy during the day, do you also:

a- Feel unable to move at sleep onset or upon waking up from sleep? _____.

b- Have vivid dreams at sleep onset or waking up from sleep? _____.

c- Feel weakness in your muscles when laughing, been surprised, angry or if excited? _____.

16. PAST MEDICAL HISTORY? _____

17. CURRENT MEDICAL PROBLEMS? _____

18. Previous Surgery(s): _____

19. Family History:

Sleep walking _____ Sleep Terror _____ Bedwetting _____

Sleep Apnea _____ Restless legs _____ Insomnia _____

Narcolepsy _____ Others _____

20. 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 coffee/tea regularly? ___Y ___N , If yes What time? _____
How much? _____. Do you drink caffeinated drinks (coffee, tea, pop) to stay
awake during the day ? _____

Any recreational drugs? _____Y _____N

Any history of recent weight change? _____ Gain _____ Loss How much? _____

Do you participate in a sport or other forms of exercise regularly? _____times per
week. What time during the day? _____

21. Please list the name of any pills for sleeping or to help you stay awake, that you have taken in the PAST.

Help You Sleep

Help You Stay Awake

22. What Medications are you Allergic to? _____

23. List medications (Prescribed or Over the Counter) that you take now:

Medication	Dose	Reason

30. What are your usual work hours? From _____ a.m./p.m. To _____ a.m./p.m

Does your work change shifts? Yes _____ No _____

31. Do you have any special needs or accommodations that we need to be aware of? Such as; assistance with communication, transferring, walking, dressing, using the restroom, or taking medications.
