Date:______________

Sleep Disorders Questionnaire

Patient Name ________________________________ **DOB**____________

Please list your usual sleep time(time into in pm and out of bed in am)during the week Bedtime: _________am/pm Waketime: _________am/pm
Please list your usual sleep time during the weekends/days not working
Bedtime: _________am/pm Waketime: _________am/pm
Do you need to use an alarm to help you wake up? ☐ Yes ☐ No
How many minutes does it take for you to fall asleep: ____ minutes

If you take naps, how many naps in a usual day: _____
How many minutes do you naps typically last: _____
Are your naps refreshing? ☐ Yes ☐ No

Do you have a bed partner? OR Have you or your bed partner noted any of the following conditions that may disrupt your sleep? Please type Yes or No

Trouble falling asleep?	**Sleep talking?**
Trouble staying asleep?	**Sleep walking?**
Crawling feelings in legs when trying to fall asleep?	**Tongue biting in sleep?** **Bedwetting?**
Leg-kicking during sleep?	**Pain interfering with sleep?**
Leg cramps during sleep?	**Nightmares:**
Waking up due to cough?	**Acting out dreams without injury:**
Waking up with reflux/heartburn?	**Acting out dreams with injury:**
Waking up to urinate 2 or more times nightly?	**Increased muscle tension when trying to sleep:**
Choking/gasping sensations?	**Racing thoughts when trying to sleep:**
Shortness of breath?	**Fear of being unable to sleep:**
Mouth breathing?	**Laying in bed worrying when trying to sleep:**
Nasal congestion?	**Early morning awakenings:**
Teeth grinding?	**Restless sleep:**
Morning headache?	**Falling asleep unexpectedly/sleep attacks:**
Morning dry mouth/throat?	**Number of pillows used/sleep position:**

PLEASE CHECK THE BOX FOR EACH PROBLEM YOU CURRENTLY HAVE:

Do you snore loudly (louder than talking or heard through closed doors)? ☐ Yes ☐ No

Do you often feel tired, fatigued or sleepy during daytime? ☐ Yes ☐ No

Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No

Do you use a sleeping medication ☐ Yes ☐ No
If Yes, the name of the SLEEP MEDICINE is: _______________

Do you drink alcohol or use special products (i.e. marijuana) to help you sleep? ☐ Yes ☐ No

SOCIAL HISTORY

Are you currently employed? ☐ Yes ☐ No

If No, what how do you spend your typical day (please list activities)? **If Yes,** what kind of work:

____

Do you exercise? ☐ Yes ☐ No

If Yes, How many days a week? _________

Do you have a history of smoking or currently smoke/use any nicotine products? ☐ Yes ☐ No

If yes, when is your last product use for the day? _________

Do you drink alcohol? ☐ Yes ☐ No

If Yes, how many drinks per week: _________

Do you drink caffeinated beverages to help you stay awake? ☐ Yes ☐ No

If Yes, how many drinks per day and what time is usually your last caffeinated drink of the day:

____

EPWORTH SLEEPINESS SCALE

How LIKELY are you to DOZE OFF or FALL ASLEEP in the following situations? You should rate your chances of dozing off not just tired. Even if you have not done some of these things recently, try to work out how they would have affected you. Please check off one box per line.

—CHANCE OF DOZING OFF—

Never	Sometimes	Often	Always	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in a public place (e.g a theater or a meeting)
☐	☐	☐	☐	As a passenger in a car for an hour without a break
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit

☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic