LAUREATE MEDICAL GROUP
Medical Excellence. Compassionate Care.
An Affiliate of Northside Hospital

SLEEP QUESTIONNAIRE

New Patients Consults

Instructions:
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 they would have affected you. Use the following scale to choose the most appropriate option for each situation.

Patient Name ______________________ Date of Birth ______________________ Today's Date ______________________

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
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 the traffic.				

The purpose of this questionnaire is to determine the nature of your sleep problem. Please try to answer these questions as accurately as possible. Your sleep partner's information may also be very helpful in our evaluation of your sleep problem; a page for her/him to fill out is included with this questionnaire.

Your name:______________________________ Today's Date:__________________

Name preference or nickname__________________

Age: ___ Date of Birth:___________ Height:______ Weight:______ Occupation: _______________________

Referring Physician:__________________________ Primary Care Physician: ________________________

Marital Status ___Single ___Married ___Partner ___Separated ___Divorced ___Widowed

Do you have a regular bed-partner? ______YES ______NO

Spouse or partner's name__________________

Have you ever had a sleep study? Yes No If yes, what year? __________

Where was it done? ____

Were you diagnosed with a sleep disorder of any kind?____

It is very important that we get copies of all your previous sleep studies done at outside facilities. If you know, please tell us the name of the doctor that ordered your studies, the doctor who read the studies, or anyone else who may have copies of the studies, and how to get in touch with them:

____

____

Even better: if you can bring copies of your studies to your visit, you will help us (and yourself) immensely.

How would you describe your sleep problem? (Check all that apply to you.)

- ☐ Difficulty falling asleep
- ☐ Waking up during the night
- ☐ Prolonged mid-night waking
- ☐ Waking up early in the morning
- ☐ Restless sleep
- ☐ Feeling sleepy or falling asleep frequently during the day
- ☐ Drowsiness on long distance drives or falling asleep while driving
- ☐ Irresistible urge to sleep during the day
- ☐ Non-restorative/non-refreshing sleep in the morning
- ☐ Difficulty waking in the morning
- ☐ Un-refreshed despite sleeping longer
- ☐ Difficulty with memory
- ☐ Difficulty with concentration
- ☐ Snoring
- ☐ Stopping breathing during sleep witnessed by bed-partner or others
- ☐ Waking with a feeling of choking or gasping
- ☐ Irritability during the day
- ☐ Awakening in the morning with a headache
- ☐ Awakening in the morning with a sore throat
- ☐ Awakening in the morning with a dry throat
- ☐ Nighttime acid reflux
- ☐ Excessive sweating during sleep
- ☐ Weight gain

- ☐ Kicking or jerking during sleep
- ☐ Banging your head or twisting at night witnessed by bed-partner or others
- ☐ Sleep walking
- ☐ Acting out dreams
- ☐ Violent behavior during sleep
- ☐ Injury to self or bed-partner during sleep
- ☐ Night terrors
- ☐ Eating during sleep
- ☐ Recurrent nightmares
- ☐ Bedwetting
- ☐ Frequent urination at night
- ☐ Feeling paralyzed or unable to move when waking or falling asleep
- ☐ Waken suddenly from sleep with an unpleasant feeling of fear , anxiety, tension, or unhappiness
- ☐ Experience vivid dream-like scenes on awakening
- ☐ Experience vivid dream-like scenes while falling asleep
- ☐ Feel sudden muscle weakness when you laugh, get angry or surprised
- ☐ Chronic pain that influences your ability to sleep
- ☐ History of depression
- ☐ History of anxiety
- ☐ Told that you grind your teeth
- ☐ Worn braces
- ☐ Told you have an overbite
- ☐ Diagnosed with TMJ
- ☐ Historical "night-owl" tendencies
- ☐ Historical "early-bird" tendencies
- ☐ Not sleepy at desired bedtime
- ☐ Not sleepy despite taking sleep medication
- ☐ Requires naps
- ☐ Need to sleep in sitting position for comfort or ability to breathe
- ☐ Need sleeping pills every night to sleep
- ☐ Requires sleeping pills intermittently
- ☐ Need sleeping pills to fall asleep
- ☐ Need sleeping pills to stay asleep
- ☐ Sleeping pills cause next day grogginess

Do you have creeping, crawling, aching, or twitching feelings in your legs (feel like you have to move them)? Yes_________ No________

Are these symptoms worse at night than during the day? Yes_____ No____

Worse when sitting or lying still in bed? Yes_____No____

Is the discomfort relieved by moving your legs or stretching? Yes____ No_____

How long has this been a problem? ____

How many hours of sleep do you usually get each night? ____________________________________

What time do you usually go to bed on weeknights? ___________ on weekends? ______________

What time do you usually get up on weekdays? ____________ on weekends? ______________

After an average night of sleep, how do you feel? ____refreshed _____fair _____drowsy, tired.

How many hours of sleep do you need to feel your best? ____ hours.

How many times do you urinate during the night? ______ times.

Do you wake up in the morning ___ with or ____without an alarm?

I take a nap about ___ day(s) each week. After a nap, I usually feel ____refreshed ____ groggy/sleepy.

I usually exercise at ______o'clock for ______ minutes.

Do you usually work: day shift? What times? ______ to ______

evening shift? What times? ______ to ______

night shift? What times? ______ to ______.

Do you work rotating shifts? How often? every _____ days. Please give details: ____________________

____

Do you sometimes fly across time zones? Yes No If yes, how often?____________________________

Your weight 10 years ago was _______lbs.

Your weight 5 years ago was ________lbs.

Your present weight is________lb

Do you have any medical illnesses (for example, high blood pressure, diabetes, etc)? If so, list them here:

____ ____________________________________

____ ____________________________________

____ ____________________________________

Have you had any surgery? If so, list here:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Do you take any medications? If so, list them and the dosages here:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Spouse, Bed Partner, or Roommate Questionnaire

Patient's name: ______________________________ Date: _______________

Your name: ________________________________

Please check any of the following that you have observed the patient doing while asleep:

- ☐ light snoring
- ☐ loud snoring
- ☐ short pauses in breathing
- ☐ long pauses in breathing
- ☐ loud snorting or gasping
- ☐ twitching of legs or feet
- ☐ grinding teeth
- ☐ wetting bed
- ☐ talking in sleep
- ☐ kicking during sleep
- ☐ frequent awakenings

For how long have you noticed these behaviors check above?

____

____

Please describe these behaviors in more detail, including how they appear or sound to you, in what part of the night they tend to occur, how often, etc.

____

____

____

____

Have you had to leave the bedroom because of this behavior? Yes No

Additional comments:____

____

____

____

____

Thank you.