

## Sleep Disorders Questionnaire

Name: \_\_\_\_\_

Age \_\_\_\_\_

Height \_\_\_\_\_

Sex \_\_\_\_\_

Weight \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Please consult your spouse/bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write in your own if one of the choices does not apply.

1. Please describe your sleep pattern as best you can: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What is the most you have ever weighed? \_\_\_\_\_

What did you weigh 5 years ago? \_\_\_\_\_

What did you weigh 1 year ago? \_\_\_\_\_

3. When did your sleep problem begin? (month and/or year) \_\_\_\_\_

4. Have you ever had a sleep study before?  YES  NO

If yes, where was the test performed? \_\_\_\_\_

When was the test performed? \_\_\_\_\_

What were the results? \_\_\_\_\_

5. Please list your current medications below:

MEDICATION	DOSE/FREQUENCY	LAST TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. My ideal amount of sleep is \_\_\_\_\_ hours per night.

**During the week I usually:**

Get up at \_\_\_\_\_ (Time)

Go to bed at \_\_\_\_\_ (Time)

Sleep a total of \_\_\_\_\_ (Hours)

PT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

During the weekend I usually:

Sleep a total of \_\_\_\_\_ (Hours)

Go to bed at \_\_\_\_\_ (Time)

Get up at \_\_\_\_\_ (Time)

7. My job requires shift work.  YES  NO

If yes, my hours are: \_\_\_\_\_

8. It usually takes me \_\_\_\_\_ minutes to fall asleep.

9. I usually wake up \_\_\_\_\_ time(s) during the night.

Please explain what wakes you up: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. I have difficulty going back to sleep once I wake up.  YES  NO

11. I snore:

Nightly                      Weekly                      Rarely                      Never

12. My snoring started at age: \_\_\_\_\_

13. I snore in all sleeping positions.  YES  NO

14. My snoring has been described as:      Mild                      Moderate                      Loud

15. I have problems with my nose or nasal breathing  YES  NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:

Nightly                      Weekly                      Rarely                      Never

17. I have been told that I toss and turn to an extreme amount.

Nightly                      Weekly                      Rarely                      Never

18. Immediately after falling asleep, I dream.

Nightly                      Weekly                      Rarely                      Never

PT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

19. I have been told that I talk or scream in my sleep.

Nightly                      Weekly                      Rarely                      Never

20. I have been told that I grind my teeth while I sleep.

Nightly                      Weekly                      Rarely                      Never

21. I wake up with a sour or stomach acid taste in my mouth.

Nightly                      Weekly                      Rarely                      Never

Last meal is eaten at what time? \_\_\_\_\_ a.m./p.m.

22. I wake up with my heart beating irregularly.

Nightly                      Weekly                      Rarely                      Never

23. I wake up at night with muscle or joint aches and pains.

Nightly                      Weekly                      Rarely                      Never

24. I have the feeling of burning or tingling in my legs or the feeling or restless legs.

Nightly                      Weekly                      Rarely                      Never

25. I feel like I cannot move after lying down, before going to sleep.

Nightly                      Weekly                      Rarely                      Never

26. I see or hear things that are not real when lying in bed, but not asleep.

Nightly                      Weekly                      Rarely                      Never

27. After a typical night's sleep, I feel stiff or achy.

Nightly                      Weekly                      Rarely                      Never

28. After a typical night's sleep, I feel:

Refreshed      Fairly Rested      Somewhat Tired      Very Drowsy

29. I take naps.                       YES  NO      If yes, how many per day? \_\_\_\_\_

If no, is there any reason why you do not take naps?

No Need                      No Time                      Work/Social Situation Does Not Permit

PT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

30. I fight sleep uncontrollably for short periods of time while sitting.

Daily          Weekly          Rarely          Never

This occurs when (circle each that applies):

Watching TV    During Meetings          At the Movies    Riding in a Car

Other: \_\_\_\_\_

31. I fight sleep when driving.

Nightly          Weekly          Rarely          Never

This last occurred when? \_\_\_\_\_

This primarily occurs (circle the one that applies):    Morning          Afternoon          Evenings

32. I have fallen asleep while driving a car.           YES  NO

If yes, how many times? \_\_\_\_\_

Approximate date of last occurrence: \_\_\_\_\_

Please describe the circumstances: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

33. I dream during my naps.

Nightly          Weekly          Rarely          Never

34. After my naps, I feel:

Refreshed    Fairly Rested    Somewhat Tired    Very Drowsy

35. I feel sudden weakness in my knees, neck, jaw, or arms when I get angry, sad, while laughing or when emotional.

Daily          Weekly          Rarely          Never

36. Drowsiness is greatest in the:    Morning          Afternoon          Evening

37. Within the last year, depression, anxiety, or stress has interfered with my sleep:

YES           NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

38. Is there a history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring?  YES  NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

39. I have lost interest in sex or have trouble functioning sexually.

Nightly                      Weekly                      Rarely                      Never

40. My spouse or bed partner has noticed that I quit breathing at night.

Nightly                      Weekly                      Rarely                      Never

41. I have headaches in the morning.

Nightly                      Weekly                      Rarely                      Never

42. Do you smoke or have you smoked?  YES  NO

If yes, how many years have (did) you smoked? \_\_\_\_\_

How many cigarettes (cigars) per day? \_\_\_\_\_

If you quit, how long ago? \_\_\_\_\_

43. Do you drink caffeinated beverages?  YES  NO

If yes, how many cups or cans per day? \_\_\_\_\_

My usual beverage is: Coffee                      Tea                      Soda

44. I consume alcohol.  YES  NO

Is yes, how often?                      Daily                      Weekly Monthly

I usually drink in the: Morning                      Afternoon                      Evening

My usual beverage is: \_\_\_\_\_

45. Are you bothered by pain during the day?  YES  NO

Nightly                      Weekly                      Rarely                      Never

46. Are you awakened by pain during the night?  YES  NO

Nightly                      Weekly                      Rarely                      Never

47. Is your present work situation satisfactory?  YES  NO

PT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

48. Underline any of the following that apply to you:

- |                    |                            |                               |
|--------------------|----------------------------|-------------------------------|
| Headaches          | Alcoholism                 | Suicidal ideas                |
| Palpitations       | Take drugs                 | Over ambitious                |
| Bowel Disturbances | Can't make decisions       | Inferiority feelings          |
| Nightmares         | Sexual problems            | Memory problems               |
| Feel Tense         | Unable to have a good time | Fainting spells               |
| Depressed          | Take antacids regularly    | Insomnia                      |
| Unable to Relax    | Tremors                    | Don't like weekends/vacations |
| Dizziness          | Shy with people            | Can't make friends            |
| Stomach trouble    | Home conditions bad        | Can't keep a job              |
| Fatigue            | Concentration difficulties | Financial problems            |
| Take sedatives     | No appetite                | Feel panicky                  |

49. Does your sleep problem disturb your sex life? (Provide any information about any significant relationships.)

50. Do you usually: (Check all that apply to you)

- Sleep with someone else in your bed
- Sleep with someone else in your room
- Provide assistance to someone during the night (child, invalid, bed partner, animal)

51. What is your age? \_\_\_\_\_

52. Do you currently smoke or have you ever smoked?  YES  NO

53. Do you have a chronic cough?  YES  NO

54. Do you get short of breath with mild exertion?  YES  NO

55. Do you ever notice any wheezing?  YES  NO