Sleep Study Questionnaire

ACCREDITED FACILITY MEMBER

Last Name: _____ First Name: _____ DOB: _____ Age: _____

Today's Date: _____ SSN: _____ Gender: _____ Height: _____

Race: _____ Weight: _____

Please describe your sleep problem, or why your doctor requested a sleep study for you:

_____

_____

_____

Have you had a sleep study before? Yes | No If yes, when and where? _____

What were the results? _____

Please list any treatments, therapies or medications you are currently using to treat your sleep problem
(Medications, stimulants, sleep-aids, CPAP or Bi-PAP therapy, dental appliances, etc.)

_____

_____

Current Status: Complete this section on the day of your study

When did you go to bed last night? _____ When did you wake this morning? _____

If you took any naps today, when and how long? _____

Do you have nasal congestion, a cold or a cough? _____

If you are in any pain or discomfort today, please describe it below:

_____

_____

_____

General Medical History – Please check all that apply

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High blood pressure		Emphysema		Deviated Septum	
Acid Reflux		Shortness of Breath		Chronic Sinus Infection	
Heart Attack		Chronic Pain/Fatigue		Anxiety/Depression	
Stroke		Fibromyalgia		Head Injury	
Diabetes (Type I or II)		Cancer			
Heart Disease		Anemia			
Asthma		Renal Insufficiency			
COPD		Thyroid Problems			

Sleep History – Please check any that may apply (you may wish to consult your bed partner)

Snoring		Claustrophobia	
Grind your teeth or jaw clenching		Sleep with your head elevated	
Difficulty going to sleep (insomnia)		Awaken in bed, unable to move	
Awaken with shortness of breath or gasping		Sudden weakness with exciting events	
Nap on a daily basis		Hallucinations before or after sleep	
Awaken with stomach acid taste in mouth		Nightmares on a regular basis	
Restless legs, frequent kicking at night		Difficulty staying awake during the day	
Falling asleep while driving		Wear supplemental oxygen but only at night	

Allergies

Are you allergic to tapes or adhesives? _____ Are you allergic to Latex? _____

Please list all other allergies you have:

_____

_____

Diet and Medications

Estimated number of caffeinated beverages and foods (chocolates) per week: ____

Estimated number of alcoholic beverages per week: ____

Do you or have you used tobacco products? _____ Enter daily amount and number of years: ____

Medications – please list all below:

_____ _____ _____

_____ _____ _____