



Sleep Disorder Questionnaire



Name: _____ DOB: _____ Age: _____ Date: _____

Primary Care Physician: _____ Height: _____ Weight: _____ Gender: F M

Marital Status: Married Never Married Divorced Widowed

What is your current occupation/job title? _____ Work Hours: _____

Medical History:

Medications: _____

Allergies: _____

Social History: _____

Caffeinated Beverages (including coffee, tea, soda, etc.): Please list the amount and frequency.

Alcohol: Please list the amount and frequency.

Tobacco: _____

Please describe your sleep problems including both nighttime and daytime symptoms.

How long have you had these problems?

What treatment have you tried to improve your sleep and was it helpful?

FAMILY HISTORY OF SLEEP DISORDERS	YES	NO	RELATIONSHIP
Insomnia			
Daytime sleepiness			
Restless leg syndrome			
Narcolepsy			
Sleep apnea			
Habitual snoring			

SYMPTOMS	YES	NO		YES	NO	
Snoring			Breathing stops during the night			
Difficulty falling asleep				Difficulty staying asleep during the night		
Sleepiness or feeling tired				Bed partner making you seek help		
Other:						

AWAKENING SYMPTOMS	Always	Sometimes	Never
Wake up short of breath			
Coughing or choking			
Rapid heart beat			
Heartburn			
Nasal congestion			
Dry mouth			
Headache			
Anxious or panicky feeling			
Legs, arms or body moving or jerking			
Bed covers extremely messy			
Vivid or frightening images			
Temporarily unable to move your body			
Momentary confusion			

DAYTIME SYMPTOMS	Always	Sometimes	Never
Feeling tired or sleepy during the day			
Struggling to stay awake			
Often feel "brain fog" or in a daze			
Feeling sleepy while driving			
Falling asleep in mid-conversation			
Trouble focusing on work			
Difficulty remembering			
Sudden muscular weakness with strong emotion			
Muscle weakness during intense emotion			
Feeling sad, depressed, anxious or irritable			

SLEEP - WAKE SCHEDULE

Do you keep a fairly regular schedule?			
What time do you go to bed on weekdays?		Weekends?	
What time do you wake up on weekdays?		Weekends?	
Do you drink alcohol before going to bed?			
Once in bed, how long does it take to fall asleep?			
Once asleep, how many times do you wake up?			
What causes you to wake up?			
Do you get up multiple times to go to the bathroom?			
How many hours do you sleep?			
Do you awaken refreshed?	Always	Sometimes	Never
How often do you take naps?	Daily	Few days a week	Few days a month Rarely/never
If you nap, how long are your naps?			

SLEEP SYMPTOMS	Always	Sometimes	Never
Difficulty falling asleep			
Trouble staying asleep			
Repeated awakenings			
Waking up too early			
Snoring or difficulty breathing			
Choking or gasping			
Morning headaches			
Dry mouth			
Tired or crampy legs when you awaken			
Leg, arm, or body jerks			
Unpleasant feelings in arms or legs when you awaken			
Irresistible desire to move legs			
Intense visual images when falling asleep			
Sleep talking			
Sleep walking			
Other behaviors			

SLEEP ENVIRONMENT	Yes	No
Do you usually sleep in the same bed every night?		
Do you watch TV, read in bed or use a computer before sleep?		
Does your partner often disrupt your sleep?		
Is your bed comfortable?		

REVIEW OF SYMPTOMS (CHECK ALL THAT APPLY)			
Weight gain		Shortness of breath	Feeling depressed
Coughing		Urinary frequency	Feeling anxious
Wheezing		Erectile dysfunction	Heartburn
Chest pain		Pain in muscles	Ankles swelling
Palpitations		Pain in joints	Abdomen discomfort
Weight change in the last 5 years			

EPWORTH SLEEPINESS SCALE				
	0 Never doze	1 Slight chance	2 Moderate	3 High
Sitting and reading				
Watching television				
Sitting inactive in a public place (eg. a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting quietly after lunch (without alcohol at lunch)				
Sitting and talking to someone				
In a car, while stopped in traffic				

BED PARTNER	YES	NO	
Do you have a regular bed partner?			
Please have your bed partner or anyone who observed you sleep recently assist in answering the questions below.			
When asleep, do other observe:	Always	Sometimes	Never
Snoring			
Loud breathing or sighing			
Breathing becomes labored			
Long pauses between breaths			
Repeated moving of arms, legs, or body			
Teeth grinding			
Sleep walking			
Sleep talking			
Acting out dreams			
	YES	NO	
Do any of the above result in sleeping in separate beds?			

Use the space below to have your bed partner describe any additional information, concerns, or problems they feel should be included for evaluation.

Has this patient ever fallen asleep during normal daytime activities or in dangerous situations?

If yes, please explain:
