LAUREATE MEDICAL GROUP

*Medical Excellence. Compassionate Care.*

AN AFFILIATE OF NORTHSIDE HOSPITAL

# *SLEEP QUESTIONNAIRE*

*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
- ☐ Bed wetting
- ☐ 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**.