SLEEP QUESTIONNAIRE

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Today's Date: _____

Name: _____**Date of Birth**: _____

Sex: _____ **Weight**: _____ **Height**: _____ **Neck Size**: _____

Referring Physician: _____

Primary Care Physician: _____

Major sleep complaint:

_____

_____

Have you had an Echocardiogram in the past year: _____

History of present illness:

_____

_____

_____

Past Medical History:

___Tonsillectomy ___Chronic lung disease (ex: COPD Emphysema)

___ Heart Failure ___ Asthma ___ High Blood Pressure

___ Thyroid disease ___ Chronic nasal problem ___ Heart Attack

___ Treatment for Depression

___ Diabetes ___ PTSD ___ Anxiety ___ Insomnia

___ Sleep Apnea

___ Oxygen dependent – If so, how many liters: _____

Other not shown above:

_____

Current Medications:

_____
_____
_____
_____
_____

Allergies:_____

Family History – 1st Degree (Grandparents, parents and siblings)
__ OSA __ High blood pressure __Cancer __Migraines
Other:
_____

Occupation: _____
Smoker: Yes or No – If yes how many per day: _____
Alcohol Consumption: Yes or No – If yes how much: _____
Caffeine Consumption: Yes or No – if yes how many cups per day: _____

Usual time in bed weekday: _____
Usual time out of bed weekday: _____

Usual time in bed weekend: _____
Usual time out of bed weekend: _____

How long does it take you to fall asleep: _____
How many times do you wake up at night: _____
How many times do you get out of bed to urinate: _____

How often do you take naps: NEVER - DAILY - WEEKENDS - SOMETIMES – NEVER

Do you Snore loudly: YES or NO
Observed Apneas: YES or NO
Tired during the day: YES or NO
Weight gain in last 12 months: YES or NO - If so, how many pounds: _____
Wake up gasping for air: YES or NO
Opiod use: YES or NO
Morning headaches: YES or NO If so, how many times per week: _____
Dry Mouth: YES or NO

Do you experience any of the following:

Vivid Dreams: YES or NO

Unable to Stay Awake: YES or NO

Loss of Strength in Leg: YES or NO

Facial Heaviness on Strong Emotions (Laugh/Angry): YES or NO

Sleep Paralysis: YES or NO

Sudden Loss of Leg Strength/Fall: YES or NO

Neck Weakness: YES or NO

Previous MSLT Done: YES or NO

Sleepwalking: YES or NO

Sleep Talking: YES or NO

Nightmares: YES or NO

Acting Dreams: YES or NO

Harming self or others: YES or NO

Restless Leg Syndrome:

Urge to Move Legs due to an uncomfortable sensation while at rest? YES or NO

Does this sensation improve with movement? YES or NO

Is the urge to move/sensation worse in the evening? YES or NO

Other leg symptoms / sensations:

_____

_____

Epworth Sleepiness

0 – Never fall asleep **1 –** Slight chance of falling asleep

2 – Moderate chance of falling asleep **3 –** High chance of falling asleep

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting down talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
Total:				

Please use the following space to add any additional information