Sleep Disorders Center

PATIENT SLEEP QUESTIONNAIRE

Patient name:______________________________ **Usual bedtime:**__________________ **AM PM**

Height:______________________________ **Usual rise time:** __________________ **AM PM**

Weight:______________________________ **Do you take naps?**______________________

Referring Physician? ______________________ **If yes, how often?** ______________________

PAST SLEEP MEDICAL HISTORY

Why did your doctor ask you to have this test?

____

What is your expectation of what will be done during this test? Is this test for observation or will you be using a PAP or dental device?

____

Have you had a sleep evaluation or test before? No Yes
If yes, when and where?

____

Have you been diagnosed with Sleep Apnea? No Yes

Do you currently use a CPAP or BIPAP machine? No Yes

If yes, where did you get your machine? What is your current pressure and settings?

____

Do you currently use a dental device for Obstructive Sleep Apnea? No Yes
If yes, where did you get your device?
What are your current settings?

____

Do you take medication to help you sleep? No Yes

If yes, what?

____

Are you a shift worker? No Yes

If yes, what hours do you normally work?

____

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CHECK ALL THAT APPLY:

I feel sleepy during the daytime
I have been told I snore
I have been told I stop breathing in my sleep
I wake up gasping or short of breath
I wake up at night coughing
I get up more than once to use the bathroom
I sometimes awaken with headaches
I am hoarse or have a sore throat in the morning
I wake up in the morning feeling unrefreshed
I breathe mainly through my mouth
I have difficulty breathing through my nose
I have gained more than 20 lbs over the last 2 years
I have difficulty falling asleep
I wake up during the night and can't get back to sleep
I wake up thrashing or hitting and have hurt myself or my partner
I act out my dreams
I sleep walk
I sleep talk
I sleep eat (eating while asleep)
I do unusual things in my sleep (For example :____)
I grind my teeth when I sleep
I wear a mouth guard for teeth grinding
Sometimes I feel uncomfortable sensations in my legs at night and feel like I just have to move them
I have been told that I kick at night
I have experienced vivid dream-like scenes upon falling asleep
I have experienced vivid dream-like scenes upon waking up
Sometimes I feel unable to move when I'm waking up or falling asleep
When I'm angry, surprised, or laugh, I feel like I'm going limp or about to fall

1. Do you feel your sleep is restless or disturbed? YES _______ NO________
2. Do you wake up irritable? YES _______ NO________
3. Does your daytime sleepiness increase memory difficulties? YES _______ NO________

SIGN:____ **DATE:**_______________________

PAST MEDICAL HISTORY (check all that apply)

- Heart disease
- Diabetes
- High blood pressure
- Pulmonary hypertension
- Stroke
- Parkinson's
- Alzheimer's disease
- ADHD
- ALS
- Depression
- Acid reflux / GERD
- Thyroid disease
- Cancer
- Emphysema / COPD / Lung disease
- Epilepsy / seizures
- Asthma
- Other

Do you smoke? No Yes If yes, list amount and how often: ____

Do you consume alcohol? No Yes If yes, list amount and how often: ____

PAST SURGICAL HISTORY (check all that apply)

Bariatric surgery Date: / /

Tonsillectomy Date: / /

Sinus surgery Date: / /

Sleep apnea surgery Date: / /

Other___________________________________ Date: / /

SIGN:____ **DATE:**____________________

Please List Any Current Medications

___

___

___

___

___

___

Please List Any Allergies/Reactions

___

___

SIGN:____ **DATE:**__________________