



Sleep Disorder Questionnaire



Name: _____ Date: _____

Date of Birth: ____ / ____ / ____ Gender: _____

Marital Status: Married ____ Never Married ____ Divorced ____ Widowed ____

Work Hours: _____

What is your current occupation / job title? _____

Requesting Physician: _____

| | |
|-----------------------------------|--|
| SYMPTOMS | |
| 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: _____ | |

Please describe your sleep problems including both night time and day time symptoms

How long have you had these problems?

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

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 | | |

SLEEP- WAKE SCHEDULE

Do you keep a fairly regular schedule? _____

What time do you go to bed on weekdays? _____ AM / PM, Weekends _____

What time do you wake up on weekdays? _____ AM / PM 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? _____

Total number of hours of sleep _____

Do you awaken refreshed? Always Sometimes Never

How often do you take naps? _____

Daily A few days a week A few days a month Rarely/never

If you nap, how long are your naps? _____

SLEEP SYMPTOMS

| | Always | Sometimes | Never |
|---------------------------------|--------|-----------|-------|
| Difficulty falling sleep | | | |
| Trouble staying asleep | | | |
| Repeated awakenings | | | |
| Waking up too early | | | |
| Snoring or difficulty breathing | | | |
| Choking or gasping | | | |
| Morning headaches | | | |
| Dry Mouth | | | |

| | Always | Sometimes | Never |
|---|--------|-----------|-------|
| 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 | | | |

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 | | | |

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 |

MEDICAL HISTORY: _____

MEDICATIONS: _____

ALLERGIES: _____

SOCIAL HISTORY:

CAFFEINATED BEVERAGES (including coffee , tea sodas etc): Please list amount and frequency.

ALCOHOL: Please list amount of alcohol and frequency.

Tobacco: _____

FAMILY HISTORY OF SLEEP DISORDERS

| | Problem | Relationship |
|--|-----------------------|--------------|
| | Insomnia | |
| | Daytime sleepiness | |
| | Restless leg syndrome | |
| | Narcolepsy | |
| | Sleep apnea | |
| | Habitual snoring | |

