Northwest SLEEP HEALTH

Sleep Disorder Questionnaire

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

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	

EPWORTH SLEEPINESS SCALE

0	1	2	3
Would never doze	Slight chance	Moderate chance	High chance

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place – for example, a theater or a meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

BED PARTNER QUESTIONS?

Do you have a regular bed partner: _____

If possible, please have your bed partner (or anyone who observed you sleep recently) help answer the questions below.

When asleep, do others 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			

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: _____

_____

_____