Sleep Questionnaire - ADULT

Name: ______________________________________ Age: __________ Today’s date: __________

Referring Provider: ____________________________ Ht: _________ Wt: _______ DOB: __________

Please answer the following questions to the best of your ability:

I have been referred for a sleep study because of:

[ ] Excessive fatigue/sleepiness  [ ] Insomnia (unable to sleep)  [ ] Snoring
[ ] Legs jerk when I sleep  [ ] I stop breathing during sleep  [ ] Violent behavior during sleep
[ ] Other _______________________

I have had a sleep study before:  [ ] Yes  [ ] No  If yes, where? _______________________________

My trouble with sleep started ______________ years ago.

SOCIAL HISTORY:
On a typical day I drink:

____ cups caffeinated coffee  ____ cups of caffeinated tea  ____ cups of caffeinated soda
____ glasses of beer  ____ glasses of wine  ____ glasses of other alcohol

Do you drink any of the above 2 hours or less before going to sleep?  [ ] Yes  [ ] No

SLEEP SCHEDULE:
During work days, I usually go to bed at:  _______ AM/PM
During work days, I usually get up at:  _______ AM/PM
I usually wake up ____ times per night.
I need to urinate ____ times per night.
I take a nap about ____ days each week.

WORK SCHEDULE:
What is your job? _________________________________________________________________
I usually work _______AM/PM to _______ AM/PM.
Commuting to/from work usually takes _________ minutes.
WHAT MY SLEEP IS LIKE:

Place a check mark beside any of the statements that are true for you.

[ ] I have been told I snore loudly.
[ ] I have been told I stop breathing in my sleep.
[ ] I am very restless sleeper.
[ ] I have injured myself or my bed partner during sleep.
[ ] I have a creeping, crawling or painful sensation in my legs when I lie down to sleep.
[ ] I have been told I grind my teeth in my sleep.
[ ] I often have frightening dreams.
[ ] I have woken from sleep feeling anxious, tense, or unhappy.
[ ] I have trouble falling asleep at night.
[ ] I often take sleeping pills in order to sleep.
[ ] When I wake at night, I have trouble falling back to sleep.
[ ] When I wake at night, I watch the clock.
[ ] I watch TV in bed.
[ ] I use a computer or other electronic device in bed.
[ ] I don’t feel sleepy at bedtime, stay up, and as a result get too little sleep.
[ ] I have had dream-like images when waking or falling asleep.
[ ] I have had the sensation of sudden weakness while awake.
[ ] I sometimes feel paralyzed when waking or falling to sleep.
[ ] Pain wakes me from sleep. Pain is located in the ______________________.
[ ] I have been depressed recently or in the past.
[ ] Other family members have been diagnosed with sleep apnea.
[ ] I am so sleepy that sometimes my work is affected.
[ ] I often “fight” sleep while driving, especially on long trips.
[ ] I have had a car accident/near miss as a result of dozing at the wheel.
[ ] I have “come to” or become alert doing things without being aware.
[ ] When I get a good night’s sleep, I feel better the next day.

OTHER COMMENTS REGARDING YOUR SLEEP THAT WE SHOULD BE AWARE OF:

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
IF POSSIBLE, PLEASE HAVE YOUR BED PARTNER, OR OTHER PERSON WHO HAS SEEN YOU SLEEP, ANSWER THE FOLLOWING:

1. How often do you see the patient sleeping? ____________________________________________

2. What is your relationship to the patient? _____________________________________________

3. What have you seen or heard?
   [ ] Light snoring
   [ ] Loud snoring
   [ ] Choking
   [ ] Snorting
   [ ] Stop breathing
   [ ] Moving/twitching or arms or legs
   [ ] Punching, hitting or kicking
   [ ] Teeth grinding
   [ ] Sleep walking
   [ ] Bedwetting
   [ ] Sitting up while sleeping
   [ ] Biting tongue
   [ ] Crying out while asleep
   [ ] Awakens complaining of pain
   [ ] Other: ________________________________________________________________-

4. Have you ever seen the patient fall asleep during the day or evening at inappropriate times, or in a dangerous situation?
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________

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