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?

   _____
   _____
   _____
   _____
   _____
   _____