Sleep Questionnaire Name _____

Height _____ Weight _____ Age _____ Neck Size _____

Present living situation w/ family alone care facility

What is/was your occupation? _____

What are/were your usual working hours? _____

What is your main sleep complaint? _____

_____

_____

_____

How long have you had the sleep problem? _____

Do you drive? Yes No

Do you feel drowsy driving? Always Sometimes Long Distance

Have you had an accident due to drowsiness? Yes No

Do you fall asleep when you don't want to? Yes No Sometimes

What time do you go to bed? On weekdays _____ On weekends _____

What time do you wake up? On weekdays _____ On weekends _____

Do you nap during the day? Yes No

If yes, how often? Daily Occasionally Rarely Uncontrollable

Are these naps refreshing? Yes No Sometimes

On average, how long does it take you to fall asleep? _____

On average, how many times do you wake up during the night? _____

How difficult is it to wake up? _____

Have you been told that you snore? Yes No

Does your snoring disturb (circle all that apply):

You Your bed partner Others in the house

Do you awaken from sleep snorting or gasping? Yes No

Do you wake with a sore throat/dry mouth? Yes No

Have you been told that you stop breathing at night? Yes No

Do you have difficulty breathing through your nose?

At night During the day Always

Have you been told that you have a deviated nasal septum? Yes No Repaired

Do you still have your tonsils? Yes No

Have you ever experienced weakness or paralysis upon:

Falling asleep Waking up

Have you experienced weakness or paralysis of the legs or jaw when in an emotional state (laughing, stress, fright)? Yes No

Have you experienced your legs jerking, twitching or tingling upon:

Falling asleep Waking up

EPWORTH SLEEPINESS SCALE

Use the following scale to describe your chance of falling asleep

1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place – for example, a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	

In a car, while stopping for a few minutes in traffic	
Total	

Do you have a history of sleep apnea in your family? Yes No

What is your medical history? _____

_____

_____

_____

_____

_____

Are you currently taking medications to help you sleep? Yes No

If yes, please list here: _____

Please list all the medications you are taking (including over the counter):

_____

_____

_____

_____

_____

_____

_____

_____

How much caffeine do you use? _____ cups per day

How much alcohol do you use? _____

Do you smoke? Yes No If yes, _____packs per day

If yes, how long have you smoked? _____years

Have you had any previous sleep studies? Yes No

If yes, where? _____

_____