

SLEEP DISORDER ADULT QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth (month/day/year): _____ / _____ / _____ Gender: Male Female

Marital Status: Never Married Married Divorced Widowed

Home Address: _____ City: _____ Zip: _____

Daytime Phone: (____) _____ Evening Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Do you do shift work or work during the night? Yes No

Who is your current employer? _____

What is your current occupation/job title? _____

Requesting provider/physician: _____

MAIN SLEEP PROBLEM (Check all that apply):

Sleepiness or feeling tired Snoring

Breathing stops during the night Difficulty falling asleep

Diffuculty staying asleep during night Bed partner making you seek help

Other: _____

Please describe your sleep problem(s) including both nighttime and daytime symptoms:

How long have you had these problems? _____

What treatment has been tried to improve your sleep and was it helpful? _____

Have you had a sleep study before? Yes No

If so, where? _____ When? _____

SLEEP ENVIRONMENT

	Yes	No
Do you usually sleep in the same bed every night?	<input type="radio"/>	<input type="radio"/>
Is your bed comfortable?	<input type="radio"/>	<input type="radio"/>
Does your bed partner go to bed or wake up at the same time you do?	<input type="radio"/>	<input type="radio"/>
Do you or your bed partner watch TV, read in bed, or use a computer before sleep?	<input type="radio"/>	<input type="radio"/>
Does your bed partner often disrupt your sleep?	<input type="radio"/>	<input type="radio"/>
If yes, how? _____		

SLEEP – WAKE SCHEDULE

The questions below about sleep and wake can vary from day to day. Do not worry about being exact, these are just your best estimates.

Do you keep a fairly regular schedule? Yes No

What time do you go to bed? _____ AM / PM

What time do you get out of bed? _____ AM / PM

Once in bed, how long does it take to fall asleep? _____

Once asleep, how many times do you wake up? _____

How much lost sleep from awakenings (in minutes)? Typical _____ Most _____

What usually causes you to wake up? _____

What time do you get out of bed to start the day? _____ AM / PM

Total number of hours of sleep at night? _____ Hours

Do you awaken refreshed and ready to begin the day?

Always Almost always Sometimes Rarely Never

How long does it typically take until you are fully awake (in minutes)? _____

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? _____

When you are free to choose your own schedule (vacation, weekends, etc.), when do you prefer to go to sleep? _____ AM / PM

When do you prefer to wake up? _____ AM / PM

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.

If you drink **caffeinated** beverages (including coffee, tea, sodas, etc.) please list your **daily** consumption.

Weekday: _____ Weekend: _____

If you drink **alcoholic** beverages (including wine, beer, liquor) please list your **daily** consumption.

Weekday: _____ Weekend: _____

If you use **tobacco** products (cigarettes, cigars, snuff, chew, etc.) please list your **daily** consumption.

Weekday: _____ Weekend: _____

SLEEP SYMPTOMS

When trying to sleep, how often do you experience the following:

	Daily	Weekly	Monthly	Rarely	Never
Difficulty <i>falling</i> asleep					
Trouble <i>staying</i> asleep					
Repeated awakenings					
Waking up <i>too early</i>					
Snoring or trouble breathing					
Choking or gasping for air					

Morning headaches					
	Daily	Weekly	Monthly	Rarely	Never
Dry mouth					
Have others say you stop breathing at night					
Sleep talking					
Sleep walking					
Leg, arm or body jerks					
Tired or crampy legs when you awaken					
Unpleasant feeling in arms or legs just at night					
Irresistible desire to move legs					
Kept awake because of bed partner					
Intense visual images when falling asleep					
Other bothersome behaviors					

AWAKENING SYMPTOMS

When waking up from sleep, how often do you notice the following:

	Daily	Weekly	Monthly	Rarely	Never
Coughing or choking					
Shortness of breath					
An irregular or rapid heart beat					
Nasal congestion or runny nose					
Stomach acid taste or heartburn					
Chest pain or pressure					
Dry mouth					
Headache					
Anxious or panicky feeling					
Legs, arms or body moving or jerking					
Bed covers extremely messy / disheveled					
Momentary confusion					
Vivid or frightening visual images					
Temporarily unable to move your body					

DAYTIME SYMPTOMS

During the day when you want to be alert and awake, how often do you experience the following:

	Daily	Weekly	Monthly	Rarely	Never
Feeling tired even after a full night's sleep					
Struggling to stay awake					
Difficult concentrating					
Dozing off (even momentarily)					
Trouble remembering					
Stress, anxiety, sadness, irritability					
Feeling sleepy while driving					
Muscle weakness or fatigue during intense emotion					

How many times have you had an accident at work or while driving because you fell asleep or were sleepy? _____

GENERAL MEDICAL HISTORY

Do you currently have, or have you ever been diagnosed with (check any that apply):

High blood pressure		COPD / Asthma / Emphysema		Liver disease
CHF / Heart failure		Anxiety / Panic disorder		Reflux / GERD
CAD / Angina		Depression		Immune disorder
Abnormal heart rhythm		Alcoholism		Arthritis
Kidney disease or failure		Drug abuse or dependence		Fibromyalgia
Stroke		Diabetes		Chronic pain disorder
Head trauma or concussion		Elevated cholesterol		Neuromuscular disease
Seizure disorder		Thyroid disease		Cancer

Please list any other health problems: _____

Please list the names of healthcare providers from whom you are currently receiving care, or have seen in the past year (If possible, include the city where they practice): _____

Please describe any past surgeries or hospitalizations: _____

Please list the medications, vitamins, herbs, and supplements you have taken in the last year. Please include both prescription and over-the-counter medications:

Medication	Dosage	Frequency	Reason	Date started

Please describe any allergies or other adverse reactions to medications. *If none, please write "none":*

REVIEW OF SYMPTOMS

Current height: _____ Weight: _____ Weight 1 year ago: _____ Weight 5 years ago: _____

Do you experience any of the following? (Check symptoms)

Headaches	Shortness of breath	Pain in muscles
Vision problems	Abdomen discomfort	Pain in joints
Nasal congestion	Diarrhea	Skin problems
Difficulty swallowing	Constipation	Feeling depressed
Chest pain	Blood in stools	Feeling anxious
Heart palpitations	Urinary frequency	Heartburn
Wheezing	Incontinence	Lower extremity edema (legs/ankles swelling)
Coughing	Erectile dysfunction	

FAMILY HISTORY OF SLEEP DISORDERS

Problem	Relationship
Insomnia	
Daytime sleepiness	
Restless legs syndrome	
Narcolepsy	
Sleep apnea syndrome	
Habitual snoring	
Other: _____	

**THANK YOU!
PLEASE RETURN PAPERWORK TO SLEEP DISORDERS STAFF**



ACCREDITED
MEMBER CENTER

M.D. Signature

Date

PATIENT LABEL



**SLEEP DISORDERS CENTER
ADULT QUESTIONNAIRE**