Dedicated Sleep

COMPREHENSIVE SLEEP QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your bed partner may be able to assist you.

***Please remember to write your name at the top of each page.**

This information will become part of your medical record and will remain confidential.

GENERAL INFORMATION:

Date questionnaire complete: _____
(Month/Day/Year)

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Page: (____) _____ May we call you at work? _____

What is the best way to reach you during the day? _____

Birth Date: _____/_____/_____ Age: _____ Sex: _____

Height: _____ Weight: _____ Marital Status: _____

SSN: _____ Occupation: _____

Contact in case
Of emergency: _____

Phone: _____

Referring Physician: _____

Primary Physician: _____

REVIEWED BY: _____ **DATE:** _____

REVIEWED BY: _____ **DATE:** _____

Dedicated Sleep

Name: _____ Date: _____/_____/_____

SUMMARY OF YOUR SLEEP PROBLEM:

1. Describe your sleep problem(s) in your own words.

_____

_____

_____

_____

_____

2. Describe how and when this problem began.

_____

_____

_____

_____

3. Describe any treatments you have received for your problem.

_____

_____

_____

4. Has this been a continuous or intermittent problem?
   a. Intermittent
   b. occasional problem
   c. frequent problem
   d. Continuous, almost every night

5. How long has your sleep problem bothered you?
   a. Longer than 2 years
   b. 1 to 2 years
   c. Several months
   d. Within the last 3 months
   e. Within the last month.

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Name: _____ Date: ____/____/____

MEDICAL HISTORY/CONDITIONS

6. List current medical conditions for which you are being treated.

Problem or diagnosis	Physician

7. List all hospitalizations and surgeries you have had. (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Problem or diagnosis	Physician

8. List medications you are currently taking. (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Name of medication	Dosage	How often	Reason

9. Please list / describe any allergies you have: _____

_____

_____

10. Do you have a family history of snoring or other sleep disorders? (*Check the appropriate response)* No Yes

If yes, please describe: _____

Name: _____ Date: ____/____/____

MEDICAL HISTORY / CONDITIONS continued:

11. Are you unable to sleep in a flat position due to shortness of breath? No Yes

12. Have you ever sustained a brain concussion, head injury or serious blow to the head? No Yes

13. Do you have spells or seizures? No Yes

14. Do you have high blood pressure? No Yes

15. Have you experienced a weight gain in the last year? No Yes
    If "yes," approximately how many pounds have you gained? _____ Pounds

16. Has your shirt collar size increase recently? No Yes
    If "yes," approximately how many inches has your collar increase? _____ Inches

17. Do you smoke? No Yes

    a. If you smoke, how many packs per day? _____ packs a day

    b. How long have you smoked? _____ years

18. Are you a former smoker? No Yes

    a. If you are a former smoker, how much? _____ packs a day

    b. How long did you smoke? _____ years

    c. When did you quit smoking? _____

19. Do you drink alcohol? No Yes

    a. If you drink alcohol, please estimate the number of drinks (including beer, wine, liquor) you have per day.
    _____ work days _____days off

    b. Do you drink alcohol after 6:00 p.m.? N R O F A
    (Circle the appropriate response, Use abbreviations at top of page.)

20. Do you drink caffeinated drinks? No Yes

    a. If you drink caffeinated drinks, please estimate the number of drinks (including soft drinks, coffee, and tea) you have per day. _____ work days _____ days off

    b. Do you drink caffeine after 6:00 p.m.? N R O F A

21. (Males) Have you experienced difficulties with sexual functions? N R O F A

22. (Females) Does your sleep problem vary according to the stage of your menstrual cycle? No Yes

23. (Females) Have you gone through menopause or had a hysterectomy? No Yes

N: Never (or No) *R: Rarely* *O: Occasionally* *F: Frequently* *A: Always* *Y: Yes*

Name: _____ Date: _____/_____/_____

YOUR SLEEP HABITS:

24.	How many hours of sleep do you usually get per night?	_____	
25.	What time do you usually go to bed?	_____work days	_____ days off
26.	What time do you usually wake up?	_____ work days	_____ days off
27.	How long does it take you to fall asleep?	_____	
28.	How many times do you typically wake up at night?	_____	
29.	If you wake up, on the average how long do you stay awake?	_____	
30.	Which shift do you work? *(Check all that apply)*	Day	Evening Night
31.	How often do you rotate shifts?	_____	
32.	Does your job require overnight travel?		N R O F A
33.	Are you able to fall asleep and awaken on a day to day, week to week basis according to your desired schedule?		N R O F A
34.	Do you nap during the day or evening?		N R O F A

THE QUALITY OF YOUR SLEEP:

35.	Do you feel refreshed after a typical night's sleep?	N R O F A
36.	Do you feel sleepy during the day even when you have slept all night?	N R O F A
37.	Do you feel refreshed after a short nap?	N R O F A
38.	Do you get sleepy while driving?	N R O F A
39.	Have you had an accident or near-accident when driving, due to excessive sleepiness?	N R O F A
40.	Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	N R O F A
41.	Are you able to fight off the excessive sleepiness?	N R O F A
42.	Do you have memory or concentration problems?	N R O F A

N: Never (or No) *R: Rarely* *O: Occasionally* *F: Frequently* *A: Always* *Y: Yes*

Name: _____ Date: ____/____/____

THE QUALITY OF YOUR SLEEP continued:

43.	Do you experience vivid dream-like scenes upon awakening or falling asleep?	N R O F A
44.	When you are angry or laugh, do you ever feel weak, as though you might fall?	N R O F A
45.	Are you ever unable to move or speak upon falling asleep or awakening?	N R O F A
46.	Do you have trouble falling asleep when you first go to bed?	N R O F A
47.	When you try to fall asleep does your mind race with many thoughts?	N R O F A
48.	When you try to fall asleep do you worry about whether or not you will be able to sleep?	N R O F A
49.	When you try to fall asleep do you feel pain?	N R O F A
50.	Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	N R O F A
51.	Are you a light sleeper, easily awakened?	N R O F A
52.	Is your sleep disrupted because of your bed partner or others in your household?	N R O F A
53.	Do you snore?	N R O F A
54.	Does your snoring stop for brief periods during the night (as seen by others)?	N R O F A
55.	Does your breathing sometimes stop during sleep (as seen by others)?	N R O F A
56.	Is your bed partner disturbed by your snoring?	N R O F A
57.	Do you wake up choking or gasping for breath?	N R O F A
58.	Do you have night sweats?	N R O F A
59.	Do you have heartburn at night?	N R O F A
60.	Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	N R O F A
61.	Do you have nasal / sinus congestion at night?	N R O F A
62.	Do you have morning headaches?	N R O F A
63.	Are you a restless sleeper, tossing and turning at night?	N R O F A

N: Never (or No) *R: Rarely* *O: Occasionally* *F: Frequently* *A: Always* *Y: Yes*

Name: _____ Date:____/____/____

THE QUALITY OF YOUR SLEEP continued:

64.	Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	N R O F A
65.	Do you experience any type of leg or back pain during the night?	N R O F A
66.	Do you wake up with sore or aching muscles or joints (including leg or back pain)?	N R O F A
67.	Do you grind or clench your teeth during sleep?	N R O F A
68.	Did you walk or talk in your sleep as a child or adolescent?	N R O F A
69.	Do you now walk or talk in your sleep?	N R O F A
70.	Do you have frightening dreams or nightmares?	N R O F A
71.	Do your dreams or nightmares awaken you?	N R O F A
72.	Do you wet your bed?	N R O F A

OTHER COMMENTS:

Are there any other aspects of your sleep problem which you feel have not been adequately covered on this questionnaire? If so, please describe below.

_____

_____