

## Sleep Medicine Network Sleep Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Weight 5 years ago \_\_\_\_\_ Peak Lifetime Weight \_\_\_\_\_

Briefly describe your sleep problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Exptations: What is the nature of assistance you expect or desire? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	No	Yes	How often	Started When	Comments/ Explanations
Do you have trouble going to sleep?	_____	_____	_____	_____	_____
Do you wake up frequently during the night?	_____	_____	_____	_____	_____
Do you wake up and have difficulty getting back to sleep?	_____	_____	_____	_____	_____
Do you wake up too early?	_____	_____	_____	_____	_____
Do you snore?	_____	_____	_____	_____	_____
Do you wake up gasping or choking?	_____	_____	_____	_____	_____
Do you wake up with a headache?	_____	_____	_____	_____	_____
Do you wake up feeling tired, disoriented, or foggy?	_____	_____	_____	_____	_____
Do you drink an alcohol before going to bed?	_____	_____	_____	_____	_____
Do you toss and turn?	_____	_____	_____	_____	_____
Do you have a restless or creeping feeling in your legs alleviated by walking or moving your legs?	_____	_____	_____	_____	_____
Do you feel extremely drowsy during the day?	_____	_____	_____	_____	_____
Do you fall asleep at inappropriate times, at meetings, the movies, ridding in a car, bus or train?	_____	_____	_____	_____	_____
Do you take naps during the day?	_____	_____	_____	_____	_____
How long do they last?	_____	_____	_____	_____	_____
Do you dream a lot?	_____	_____	_____	_____	_____
Do you dream during naps?	_____	_____	_____	_____	_____
Do you dream soon after you lie down?	_____	_____	_____	_____	_____
Do you hallucinate before or after sleeping?	_____	_____	_____	_____	_____
Do you ever feel like you cannot move soon after lying down or just after awakening?	_____	_____	_____	_____	_____
Do you ever feel sudden weakness in knees, neck, or arms when laughing, sad, angry or emotional?	_____	_____	_____	_____	_____

	No	Yes	How often	Started When	Comments/ Explanations
Does your speech become slurred or mumbled when you are tired?	___	___	___	___	___
Does your jaw suddenly go slack when telling a joke or talking so that your speech becomes slurred or mumbled?	___	___	___	___	___
Do you ever find yourself going somewhere and do not remember how you got there?	___	___	___	___	___
Do you ever find yourself doing something and do not remember starting it?	___	___	___	___	___
Have you ever been through long periods of stress?	___	___	___	___	___
Have you had any head injuries?	___	___	___	___	___
Describe: _____					

**SLEEP DISTURBANCE HISTORY:**

Do you talk in your sleep?	___	___	___	___	___
Did you ever wake up screaming?	___	___	___	___	___
Did you ever have very bad nightmares?	___	___	___	___	___
Did you ever sleepwalk?	___	___	___	___	___
Did you ever have a bed wetting problem?	___	___	___	___	___
Do you grind your teeth at night?	___	___	___	___	___
Do you wake up coughing?	___	___	___	___	___
Do you wake up with a stomach acid-like taste in your mouth?	___	___	___	___	___
Do you sleep with more than one pillow at night?	___	___	___	___	___
Are you short of breath or wheezing when you wake up?	___	___	___	___	___
Do you wake up to go to the bathroom more than once?	___	___	___	___	___

When you wake up, how is your heart beating? Fast? \_\_\_\_\_ Slow? \_\_\_\_\_ Regular? \_\_\_\_\_

Do you usually drink coffee, tea, chocolate, cola, or other caffeinated beverages within 3 hours of bedtime? Yes No

Estimate, for an average day, your daily consumption of:

Coffee/tea \_\_\_\_\_ cups Tea \_\_\_\_\_ cups Soda \_\_\_\_\_ cups

Do you drink alcoholic beverages? Yes No

Assuming the following drinks are equivalent - 12 oz beer/ 5 oz wine/ 3 oz whiskey, gin or vodka -

then: How many drinks do you have in a usual weekday? \_\_\_\_\_ weekend? \_\_\_\_\_

Do you drink alcohol within 2 hours of bedtime? yes No

Do alcoholic beverages alter or interfere with your sleep? yes No

Have you ever used alcohol in order to get to sleep? Yes No

Have you ever sought treatment/conseling for an alcohol problem? yes No

Smoking history (cigarettes, cigars, pipe) :

No \_\_\_\_\_ Yes \_\_\_\_\_ Yr Started \_\_\_\_\_ Stopped \_\_\_\_\_  
Packs/ day \_\_\_\_\_ # cigars/pipes/day \_\_\_\_\_

Did you ever do shift work, get by on little sleep, or sleep days?

Duration: \_\_\_\_\_ Shift(s) worked: \_\_\_\_\_ Shift Changes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take sleeping pills? No \_\_\_ Yes \_\_\_

- a. \_\_\_\_\_
- b. \_\_\_\_\_

Pre or Post Menopause \_\_\_\_\_

Family History of Sleep Problems: (please describe): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any other complaint that relates to your sleep problem or any problems your sleep problem may have caused or aggravated (in the family, at work, athletic ability): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

**Currently:** Do you have any of the following?

**Past History:** Have you ever had any of the following?

**General**

Tire easil Yes No  
Marked weight change Yes No  
Night sweats Yes No  
Persistent fever Yes No  
Sensitivity to heat or cold Yes No

**Skin**

Rashes Yes No  
Change in hair or nails Yes No

**Eyes**

Change in the vision, double vision Yes No  
Change in hearing Yes No  
Ringing in ears Yes No  
Discharge Yes No

**Nose**

Change of smell Yes No  
Obstruction Yes No  
Excessive discharge Yes No  
Bleeding Yes No  
Sinus infections Yes No  
CAT scans Yes No

**Mouth**

Sore gums or tongue Yes No  
Lumps or ulcers Yes No

**Diseases**

Measles Yes No \_\_\_\_\_  
Mumps Yes No \_\_\_\_\_  
Infections Mononucleosis Yes No \_\_\_\_\_  
Tuberculosis Yes No \_\_\_\_\_  
Pneumonia/Pulmonary Disease Yes No \_\_\_\_\_  
Asthma Yes No \_\_\_\_\_  
Hepatitis/Liver Disease Yes No \_\_\_\_\_  
Rheumatic Fever Yes No \_\_\_\_\_  
Kidney disease Yes No \_\_\_\_\_  
Arthritis Yes No \_\_\_\_\_  
High blood pressure Yes No \_\_\_\_\_  
Bleeding tendency Yes No \_\_\_\_\_  
Cancer Yes No \_\_\_\_\_  
Diabetes Yes No \_\_\_\_\_  
Heart disease Yes No \_\_\_\_\_  
HIV/Aids Yes No \_\_\_\_\_  
Any other illnesses: Yes No \_\_\_\_\_

**Year**

**Operations**

Tonsillectomy Yes No \_\_\_\_\_  
Appendectomy Yes No \_\_\_\_\_  
Gall Bladder Yes No \_\_\_\_\_  
Nasal Yes No \_\_\_\_\_  
Heart Yes No \_\_\_\_\_  
Thyroid Yes No \_\_\_\_\_

**Year**

