Sleep Disorder Questionnaire

Patient's Name _____ Age _____ Sex _____ Date of birth _____

Normal bedtime? _____ Normal wake up time? _____ Does your work/sleep schedule change? Yes / No

How tall are you? _____ Feet _____Inches

How much do you weigh? _____lbs. Have you recently gained weight? Yes / No

List current medications prescribed by your doctor _____

Indicate if you have the following symptoms and how frequently they occur.

Rarely or never	(1)	Frequently	(3)
Some of the time	(2)	Often or most of the time	(4)

- I am sleepy during the day though I have slept through the night. _____
- I am tired during the day though I have slept through the night. _____
- I require a nap to remain awake during the evening. _____
- I fall asleep when watching TV even though I try to stay awake. _____
- I fall asleep when I am driving. _____
- I have fallen asleep during routine situations. _____
- I notice swelling or puffiness in my ankles or feet at night. _____
- I sweat at night when asleep without being hot. _____
- I wake in the morning with headaches. _____
- I am hoarse in the morning when I wake. _____
- I have been told that I snore loudly even when sleeping on my side. _____
- I have been told I snore only when sleeping on my back. _____
- My snoring disturbs other people. _____
- I have been told that I stop "breathing" at night. _____
- I wake up "gasping for breath". _____
- I kick or twitch my legs at night prior to falling asleep. _____
- I have been told I kick or twitch my legs or arms when sleeping. _____
- I have aching or "crawling " sensations at night. _____
- I wake up with heartburn or gas pains. _____
- I wake up at night and can not go back to sleep no matter how hard I try. _____
- I lie awake for half-an-hour or more before I fall asleep. _____
- When I am angry, surprised, or laugh, I feel like I am going to "black-out". _____
- I experience vivid, life-like scenes when I am very tired. _____
- I wake and can not move. _____
- I have been told that I grind or clench my teeth when sleeping. _____

Please circle the appropriate answer:

- Do you use high blood pressure medication? Yes / No
- Do you currently use oxygen at night? Yes / No
- Do you currently use CPAP? Yes / No
- Do you currently smoke? Yes / No
- Have you ever smoked? Yes / No
- Do you use alcohol prior to bedtime? Yes / No
- Have you had a tonsillectomy? Yes / No

Do you have the following:

- Congestive Heart failure Yes / No
- Previous Heart condition Yes / No
- Irregular Heart beat Yes / No
- Hypertension Yes / No
- Diabetes Yes / No
- Thyroid Problems Yes / No
- Emphysema Yes / No
- Chronic Sinus Problems Yes / No
- Asthma Yes / No