



Name: _____ **Age:** _____ **Gender:** Male Female

The following questions are about your night's sleep, morning awakening and daytime symptoms

Sleep Symptoms **Nightly** **Weekly** **Monthly** **Rarely** **Never**

Difficulty falling asleep?					
Difficulty staying asleep?					
Repeated awakenings					
Waking up too early					
Snoring or trouble breathing					
Chocking, gasping for air					
Morning headaches					
Dry mouth					
Sleep walking					
Sleep talking					
Teeth grinding					
Nightmares					
Kick excessively during sleep					
Restless sleep					
Unpleasant feeling in arms or legs					
Irrisistable desire to move legs					
Kept awake because of bed partner					
Intense visual images when falling asleep/waking up?					
Feel afraid of falling asleep					
Bedwetting					

Other: _____

Awakening Symptoms **Daily** **Weekly** **Monthly** **Rarely** **Never**

Awaken unrefreshed					
Difficulty awakening					
Feel tired after sufficient sleep					
Morning headaches					
Temporarily unable to move					
Bed covers extremely messy					
Anxious or panicky feeling					
Momentary confusion					
Stomach acid taste					
Nasal congestion					
Irregular or rapid heart beat					
Experience dreamlike scenes upon awakening					
Awakened by pain					

Daytime Symptoms **Daily** **Weekly** **Monthly** **Rarely** **Never**

Tired during the day after a full night's sleep					
Struggling to stay awake					
Difficulty concentration					
Dozing off					
Trouble remembering					
Avoiding social situations					
Daytime sleepiness					
Sudden muscular weakness with strong emotion					
Feeling sleepy while driving					
Falling asleep in inappropriate situations					
Hyperactive, inattentive					
Difficulty focusing					
Have trouble at work or home because of sleep					

Sleep-Wake Schedule: Schedules can vary from night to night. Do not worry about being exact, these are your best estimates and reflects your average day sleep wake schedule

Do you keep a fairly regular schedule Yes No

What time do you go to bed? Weekdays _____ Weekends _____

What time do you get up? Weekdays _____ Weekends _____

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

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

If you awaken during the night, how long to fall back to sleep: _____

Total number of hours of sleep at night? _____

Do you awaken refreshed and ready to begin the day? _____

Do you nap during the day? Daily A few days a week A few days a monthly Rarely/Never

Specify _____

If you nap, how long are your naps? _____

Are your naps refreshing Yes No

When you are free to choose your own schedule (vacations, weekends) when do you prefer to go to sleeps? _____ 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. Please list daily consumption.

1. Caffeinated beverages (coffee, tea, sodas, etc). Yes No

Weekday _____ Weekend _____

How close to bedtime do you drink caffeinated beverages? _____ -

2. Do you drink Alcoholic beverages (beer, wine, liquor)? Yes No

How much? _____ drinks per (day/week/month)

Weekday _____ Weekend _____

3. Do you use Tobacco products (including cigarettes, cigars, snuff, chew, etc) Yes No

How much per day? _____ Number of years _____

Have you previously smoked? Yes No

4. Non prescription, over the counter & other drugs. Please list

Do you exercise regularly Yes No

If so what time of day: _____

In response to intense emotion (laughter, anger, surprise), have you felt a sudden muscle weakness in either your legs, arms, neck or have you ever falling to the ground? Yes No

Any additional information/concerns regarding your sleep?

Do you have a bed partner or share a bedroom? Yes No

If so, please ask him/her to fill out the following questionnaire. She/he may observe sleep behaviors that the person sleeping cannot notice.

Name _____ Age _____

(Name of person filling out the bed partner questionnaire)

How often do you observe this person's sleep? Nightly Often Sometimes

BED PARTNER QUESTIONNAIRE

When asleep do others observe:	Nightly	Weekly	Monthly	rarely	Never
Snoring					
Loud breathing or sighing					
Labored breathing					
Struggling to breath					
Long pauses between breaths					
Stops breathing					
Repeated kicking of legs					
Repeated moving of arms					
Thrashing or moving of the body					
Sleep talking					
Sleep walking					
Teeth grinding					
Nightmares					
Act out nightmares					
Excessive sweating					
Others:					

Describe other concerns, additional information you feel should be evaluated _____

On a scale of 1-10 (10 being the loudest) How loud is the snoring?

1 2 3 4 5 6 7 8 9 10

General Medical History:

Do you have or have you ever been diagnosed with (check any that apply).

- | | | |
|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Head trauma/concussion | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Low thyroid | <input type="checkbox"/> High thyroid disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/panic disorder | <input type="checkbox"/> Drug abuse/dependence | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> TB | <input type="checkbox"/> Bleeding disorder |

Please describe if necessary or list any other health problems: _____

Please list or describe any past surgeries or hospitalizations? _____

Please describe any allergies, side effects or other adverse reactions to medications. If none, please write in

“none”: _____

Family Medical History:

	Father	Mother	Siblings	Father's parents	Mother's parents	Aunts/Uncles
Allergies						
Alcoholism						
Asthma						
Bleeding disorder						
Cancer						
Diabetes						
Glaucoma						
Epilepsy						
Heart Disease						
Heart attach						
High Blood Pressure						
Kidney disease						
Mental illness						
Migraines						
Stoke						
Thyroid disease						
Restless Leg Syndrome						
Anemia						
Skin disease						

Others medical conditions please indicate_____

Does anyone in the family have the following sleep problems?

	Father	Mother	Siblings	Father's parent	Mother's parents	Aunts/uncles
Sleep talking						
Bedwetting						
Needs sleep medication						
Narcolepsy						
Insomnia						
During the day muscles become weak with laughter						
Daytime sleepiness						
Sleep terrors						
Nightmares						
Snoring						
Breathing pauses in sleep						
Sleep walking						
Others:						

This is the end of the questionnaire. We thank you for your time in filling out this important questionnaire. This information will assist the physician in your evaluation.