Sleep Disorders Questionnaire

Name _____DOB_____Date_____

Please list your usual sleep time during the week

Bedtime: ____: ____ Waketime: ____: ____

Please list your usual sleep time during the weekends/days not working

Bedtime: ____: ____ Waketime: ____: ____

Do you need to use an alarm to help you wake up? ☐ Yes ☐ No

How many minutes does it take for you to fall asleep: _____minutes

If you take naps, how many naps in a usual day: _____

How many minutes do your naps typically last: _____minutes

Are your naps refreshing? ☐ Yes ☐ No

Have YOU or your bed partner noted any of the following conditions that may disrupt your sleep? Please write Yes or No

Trouble falling asleep?	**Sleep talking?**
Trouble staying asleep?	**Sleep walking?**
Crawling feelings in legs when trying to fall asleep?	**Tongue biting in sleep? Bedwetting?**
Leg-kicking during sleep?	**Pain interfering with sleep?**
Leg cramps during sleep?	**Nightmares:**
Waking up due to cough?	**Acting out dreams without injury:**
Waking up with reflux/heartburn?	**Acting out dreams with injury:**
Waking up to urinate 2 or more times nightly?	**Increased muscle tension when trying to sleep:**
Choking/gasping sensations?	**Racing thoughts when trying to sleep:**
Shortness of breath?	**Fear of being unable to sleep:**
Mouth breathing?	**Laying in bed worrying when trying to sleep:**
Nasal congestion?	**Early morning awakenings:**
Teeth grinding?	**Restless sleep:**
Morning headache?	**Falling asleep unexpectedly/sleep attacks:**
Morning dry mouth/throat?	**Number of pillows used under head:**
Do you have a bed partner?	**Preferred Sleep position:**

PLEASE CHECK THE BOX FOR EACH PROBLEM YOU CURRENTLY HAVE:

Do you snore loudly (louder than talking or heard through closed doors)? ☐ Yes ☐ No

Do you often feel tired, fatigued or sleepy during daytime? ☐ Yes ☐ No

Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No

Do you use a sleeping medication now ☐ Yes ☐ No

If Yes, the name of the SLEEP MEDICINE: _____

List prior SLEEP MEDICINES tried: _____

Dr. Mashayekhi, Sleep Medicine Specialist

SOCIAL HISTORY

Are you currently employed? ☐ Yes ☐ No

If No, what how do you spend your typical day (please list activities)? **If Yes,** what kind of work:

_____

Do you exercise? ☐ Yes ☐ No

If Yes, How many days a week? _____

Do you have a history of smoking or currently smoke/use any nicotine products? ☐ Yes ☐ No

If yes, what type? _____ How much and how many years? _____

What time is your last product use for the day? _____

Do you drink alcohol? ☐ Yes ☐ No

If Yes, how many drinks per night _____and how many nights per week?_____

Do you drink alcohol or use special products (i.e. marijuana) to help you sleep? ☐ Yes ☐ No

Do you use caffeinated products to help you stay awake? ☐ Yes ☐ No

If Yes, What kind of caffeinated products: _____

How many per day: _____ What time is your last caffeinated product of the day : _____

EPWORTH SLEEPINESS SCALE

How LIKELY are you to DOZE OFF or FALL ASLEEP in the following situations? You should rate your chances of dozing off not just tired. Even if you have not done some of these things recently, try to work out how they would have affected you. Please check off one box per line.

—CHANCE OF DOZING OFF—				
Never	**Sometimes**	**Often**	**Always**	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in a public place (e.g a theater or a meeting)
☐	☐	☐	☐	As a passenger in a car for an hour without a break
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit
☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic