



Your choice for comprehensive sleep medicine.

CONFIDENTIAL SLEEP QUESTIONNAIRE

NAME: _____

AGE: _____ DATE OF BIRTH _____ DATE _____

HEIGHT _____ FEET _____ INCHES WEIGHT _____ POUNDS

SLEEP HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH A SLEEP DISORDER? YES NO
(IF YES, BRIEFLY DESCRIBE) _____

BRIEFLY DESCRIBE YOUR SLEEP PROBLEM:

USUAL BEDTIME ON WORKDAYS _____ ON DAYS OFF _____
HOUR OF ARISING ON WORKDAYS _____ ON DAYS OFF _____
USUAL AMOUNT OF SLEEP WORKDAYS _____ ON DAYS OFF _____

LENGTH OF TIME IT TAKES TO FALL ASLEEP _____ HOURS _____ MINUTES
HOW MUCH SLEEP PER NIGHT DO YOU NEED? _____ HOURS _____ MINUTES

DO YOU HAVE AWAKENINGS DURING SLEEP? YES NO

PER NIGHT _____ USUAL LENGTH _____ HOURS _____ MINUTES

SPECIFIC CAUSES _____

DURING THE TIME IT TAKES YOU TO FALL ASLEEP, DO YOU:

HAVE THOUGHTS RACING THROUGH YOUR HEAD? YES NO
FEEL SAD OR DEPRESSED? YES NO

DO YOU WAKE UP WITH A DRY MOUTH?	YES	NO
DO YOU WAKE UP WITH A HEADACHE?	YES	NO
HAVE YOU FALLEN OUT OF BED AS AN ADULT?	YES	NO
DO YOUR LEGS TWITCH/JERK WHILE YOU SLEEP?	YES	NO

ARE YOU SLEEPY DURING THE DAY? YES NO

WHEN DID THE DAYTIME SLEEPINESS BEGIN? _____

HAS THERE BEEN ANY RECENT CHANGES IN YOUR SLEEPINESS?	YES	NO
ARE YOU SO SLEEPY DURING THE DAY THAT YOUR WORK IS AFFECTED?	YES	NO
DO YOU "DOZE OFF" DURING THE DAY?	YES	NO
DO YOU TAKE RESTS WITHOUT FALLING ASLEEP?	YES	NO
DO YOU GET SLEEPY WHEN INACTIVE?	YES	NO
HAVE YOU FALLEN ASLEEP AT INAPPROPRIATE TIMES?	YES	NO

WHEN DO YOU FUNCTION BEST?

MORNING AFTERNOON MID-DAY EARLY EVENING

DO YOU TAKE NAPS DURING THE DAY? YES NO

DO YOU TAKE PLANNED NAPS? YES NO

PER WEEK _____ # PER DAY _____ USUAL LENGTH _____

DO YOU HAVE SPONTANEOUS NAPS (WHILE WATCHING TV, READING, RIDING IN A CAR, ETC.) YES NO

PER WEEK _____ # PER DAY _____ USUAL LENGTH _____

ARE YOUR NAPS REFRESHING?	YES	NO
ARE YOUR NAPS FOLLOWED BY GROGGINESS?	YES	NO
DO YOU DREAM DURING YOUR NAPS?	YES	NO
DO YOUR NAPS AFFECT YOUR NIGHT TIME SLEEP?	YES	NO

DO YOU HAVE MEMORY PROBLEMS? YES NO

HAVE YOU EVER DONE SOMETHING AND NOT REALIZED UNTIL LATER THAT YOU HAD DONE IT? YES NO

HAVE YOU EVER EXPERIENCED SUDDEN WEAKNESS IN YOUR LEGS (OR FACE, ETC.) WHILE AWAKE, PARTICULARLY IN EMOTIONAL SITUATIONS? YES NO

HAVE YOU EVER FELT PARALYZED OR UNABLE TO MOVE WHEN WAKING UP OR FALLING ASLEEP? YES NO

HAVE YOU EVER HAD HALLUCINATIONS OR DREAMLIKE IMAGES WHEN YOU WERE NOT ACTUALLY SLEEPING? YES NO

Please list all medications you are presently taking, including all non-prescription. Please list NAME, DOSEAGE and FREQUENCY.
