



484

Sleep Disorder Center
Phone: 860-545-2996 Fax: 860-545-5080

SLEEP QUESTIONNAIRE

Name: _____

Date of Birth: _____

Date completed: _____

Referring Physician: _____ M.D.

If the referring physician is not your primary physician and/or if you wish another physician to receive a copy of the results of this sleep study, please write his or her name and address below:

Please **complete** the sleep questionnaire and **bring** the questionnaire when you come to the sleep disorder center for your sleep test. This information is confidential.

Please **complete all parts of the questionnaire.** This information will help your doctor and the sleep specialist evaluate your sleep study.

Part 1 Summarize your sleep problem

Describe what you (or your bed partner) believe is the *main problem* with your sleep.

Describe daytime problems you have.

What is your regular bed time? _____ What is your regular wake time? _____
Are they different on the weekend, if yes, please list your weekend/days off bed time and wake time.

Do you do shift work? Yes No If yes, please list the shifts you work _____

What is your current weight? _____ lb. What was your weight when you were twenty? _____ lb.

Have you gained weight during the past 6 months? Yes No How many pounds? _____ lb.



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Please list any health problems (for example, high blood pressure, heart disease, diabetes, a thyroid condition, seizures, stroke, arthritis) that you are being treated for now or that you have been treated for in the past.

Please list operations you have had (**particularly** sinus, nose, facial or throat surgery)

Prescription Medications (dose, frequency)

Seizure medications? Yes No Please list: _____

Other Medications:

N = never or rarely **S** = sometimes **A** = often or always

Check Best Answer

Aspirin, buffered aspirin, enteric-coated aspirin (Ecotrin, Bufferin, etc.) **N** **S** **A**

For indigestion (antacids, Maalox, Riopan, Mylanta; H-2 blockers, including Pepcid, Tagamet, Axid, etc.) **N** **S** **A**

Nasal decongestants (Afrin, NeoSynephrine) **N** **S** **A**

Allergy or hay fever pills or tablets (including antihistamines) **N** **S** **A**

Sleeping pills (Somenex, Tylenol PM, etc.) **N** **S** **A**

Diet pills (prescription or non-prescription) **N** **S** **A**
 Name(s) of diet pills _____

Non-prescription stimulants (NoDoz, Vivarin, caffeine tablets) **N** **S** **A**

Oxygen? **Yes** **No**
 Liters Per Minute (LPM) _____

Have you had any sleep studies in the past? **Yes** **No**

When and where?

N= never or rarely **S**= ometimes **A** = often or always

Check Best Answer

Do you **snore** during your sleep? **N** **S** **A**

Is your snoring **loud** or does your snoring *bother others*? **N** **S** **A**

Has anyone ever seen you **stop breathing** in your sleep? **N** **S** **A**

Does your **nose block up** when you lie down or try to sleep? **N** **S** **A**

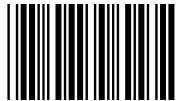
Do you wake up choking or gasping for breath? **N** **S** **A**



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- Do you wake up with a **sour taste** in your mouth or with **heartburn**? N S A
- Do you wake up at night wheezing or coughing? N S A
- Do you **grind** your teeth during sleep? N S A
- Do you **wake up with a headache in the morning**? N S A
- Do you feel rested and alert after a full night's sleep? N S A
- Do you have **nightmares** (frightening dreams)? N S A
- Do you see vivid, dream-like images or scenes (**hallucinations**) as you fall asleep or as you wake up from regular sleep or naps? N S A
- Do you feel weak or **paralyzed** as you **wake up** or **fall asleep**? N S A
- Have you suddenly **become weak** when laughing at a joke or experiencing a very strong emotion (anger, fright)? N S A
- Did your sleep problem begin after a specific event? Yes No Please explain below:

- How do you sleep when you are **away**, compared to sleeping at home?
 Better Same Worse
- How often do you fall asleep in places **other** than your bedroom? N S A
- Do thoughts **race through you mind** when you try to fall asleep? N S A
- Do you worry about things when you are trying to fall asleep? N S A
- Do you feel **sad and depressed**, when you are trying to fall asleep? N S A
- Do you have trouble falling asleep because of **aches and pains**? N S A
- Does **light** disturb your ability to fall asleep? N S A
- Does **noise** interfere with your ability to fall asleep? N S A
- Do you ever feel a **restlessness** of your **legs**, (*nervous legs; a creeping or crawling sensation in your legs*), while you are lying in bed before sleep or when you wake up?
How many times per week does this occur?
 0 1 2 3-4 5-6 always
- Do arm movements or leg movements arouse you from sleep? N S A
- How many times do you wake up at night and then go back to sleep?
 0 1 2-3 4-5 6-7 8-10 >10
- Do bodily pains disturb you sleep? If yes, where? Yes No



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N = never or rarely **S** = sometimes **A** = often or always

Check Best Answer

Do you use non-drug therapies (such as biofeedback, massage, magnets, acupuncture, or hot baths) to help you sleep?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Do you use marijuana to help sleep?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Do you use alcohol to help you sleep or nap?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
How many drinks of alcohol do you consume per day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1-3	<input type="checkbox"/> ≥ 4
Do you have difficulty driving , because of sleepiness or fatigue?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
During the past 6 months how many accidents or near automobile accidents have you been involved, because of sleepiness?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >5		
How many daytime naps do you take each day?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >5		
Do you feel refreshed and awake after a daytime nap?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
How many cups of coffee, tea or cocoa do you drink each day?	_____ cups		
How many cups of coffee, tea or cocoa within 2 hours of bedtime?	_____ cups		
How many cans of cola, (or other cold drinks with caffeine, for example Surge, iced tea, or Mountain Dew), do you drink, daily?	_____ cans		
Have you used recreational drugs, including marijuana, cocaine, heroin, angel dust, and crack) within the last 6 months? Please describe:	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A

Do you sleep better after physical exercise?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Do you exercise, regularly?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Do you smoke cigarettes within 2 hours of bedtime?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Do you use tobacco products other than cigarettes?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
What tobacco products do you use?			

Do bladder problems or incontinence disturb your sleep?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
How many times do you wake up to urinate during the night?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >5		
Are you unhappy about the loving relationships in your life?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Are you unhappy about your social life?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
During the past six months, how much have your been bothered by:			
Increased irritability or lack of patience?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Increased difficulty remembering things?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Feeling sad?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Being less involved with family, friends or activities?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Having trouble concentrating on everyday tasks?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A
Difficulty making decisions?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> A

Patient Signature: _____ Date: _____