

## PRELIMINARY SLEEP QUESTIONNAIRE

Please answer all of the following questions and bring this questionnaire with you to your appointment.

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Briefly describe your problem**

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How long have you had your sleep-related problems? \_\_\_\_\_ years/months

Using the following rating scale, to what extent do you currently experience the following symptoms?  
(If not applicable, circle N/A)

	<u>M I L D</u>			<u>M O D E R A T E</u>				<u>S E V E R E</u>			
Daytime Sleepiness	1	2	3	4	5	6	7	8	9	10	N/A
Snoring	1	2	3	4	5	6	7	8	9	10	N/A
Difficulty Falling Asleep	1	2	3	4	5	6	7	8	9	10	N/A
Difficulty Staying Asleep	1	2	3	4	5	6	7	8	9	10	N/A
Walking, Talking or other Unusual Behaviors During Sleep	1	2	3	4	5	6	7	8	9	10	N/A
Daytime Deficits in Concentration, Memory, Motivation or Mood	1	2	3	4	5	6	7	8	9	10	N/A
Obtain too little sleep	1	2	3	4	5	6	7	8	9	10	N/A
Obtain too much sleep	1	2	3	4	5	6	7	8	9	10	N/A

At what time do you typically go to bed and awake?

On weekdays (Sun-Thurs) \_\_\_\_\_ On weekends (Fri-Sat) \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_

How many times do you typically awaken during the night? \_\_\_\_\_

On a typical night, is your sleep disturbed by any of the following?

Asthma	YES	NO	Heartburn	YES	NO
Nightmares	YES	NO	Difficulty breathing	YES	NO
Persistent cough	YES	NO	Choking or need for air	YES	NO
Regurgitation	YES	NO	Nasal congestion	YES	NO
Panic	YES	NO	Sweating	YES	NO

Name \_\_\_\_\_ Date \_\_\_\_\_

Heart pounding	YES	NO	Racing thoughts, worries	YES	NO
Headache	YES	NO	Restless legs/need to move	YES	NO
Muscle cramps	YES	NO	Noises in sleep area	YES	NO
Thrashing movements	YES	NO	Bed partner	YES	NO
Hunger or thirst	YES	NO	Child/pet care needs	YES	NO
			Heat or cold	YES	NO
			Light in sleep area	YES	NO
			Need to urinate/night	0	1 2 3 4 5

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
<b>Total score (add the scores up)</b> (This is your Epworth score)	_____

**Past Medical History:** (Please check if applicable)

- High Blood Pressure   
  Diabetes   
  Stroke   
  Heart Problems   
  Lung Problems  
 Glaucoma   
  Cancer   
  Anemia   
  Liver disease   
  Blood Clots  
 Epilepsy   
  Gastrointestinal   
  Gynecological Problems  
 Other: \_\_\_\_\_

**Surgical History:** \_\_\_\_\_

**Habits:** Alcohol \_\_\_\_\_ # drinks/week      Cigarettes \_\_\_\_\_ # cig/day x \_\_\_\_\_ # years      \_\_\_\_\_ year quit

Other tobacco usage: \_\_\_\_\_ Current frequency: \_\_\_\_\_

Caffeine \_\_\_\_\_ # cups/day      Recreational Drugs: \_\_\_\_\_

**Family History:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Migraine           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Anemia        |
| <input type="checkbox"/> Cerebral Aneurysm  | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Blood Clots   |
| <input type="checkbox"/> Parkinsons         | <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Alzheimer/Dementia | <input type="checkbox"/> Glaucoma            |  |

Other: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Current Medications:**

Medication	Dosage	Reason

**Review of Current/Recent Symptoms:** (check all that are applicable)

- General:     Fever         Chills         Weight Loss     Weakness
- Skin:         Rash         Itching
- Hematopoietic:  Bruising     Bleeding     Anemia
- HEENT:      Vision changes     Double vision     Glaucoma         Hearing problems  
 Vertigo
- Respiratory:  Cough         Coughing Blood         Shortness of Breath         Infections
- Cardiovascular:  Chest Pain     Murmurs         Pain in legs with walking     Swelling in the legs
- Gastro-Intestinal:  Constipation     Diarrhea         Bleeding         Hemorrhoids     Indigestion  
 Hepatitis
- Genito-Urinary:  Burning         Bleeding leaking (incontinence)     Flank pain         Loss of erections
- Muscle-skeletal:  Joint Pain     Weakness         Back pain         Cramps
- Neurologic:     Headache         Dizziness         Seizures         Blackouts         Depression  
 Sleeping problems
- Other: \_\_\_\_\_

Other Comments: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date