

Patient Name: _____

Date: _____

SLEEP DISORDERS PATIENT QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

- 1) What time do you go to bed? _____
- 2) How long does it take you to fall asleep once in bed? _____
- 3) While waiting to fall asleep do you feel an unsettled or restless sensation in your limbs (i.e. legs)? YES NO
 - If so do you feel that moving your limbs temporarily relieves this sensation? YES NO
- 4) Do you kick your legs frequently when you are asleep? YES NO
- 5) Once asleep, how many times do you awaken during the night? _____
- 6) Do you know what awakens you? _____
- 7) How long does it take you to fall back to sleep? _____
- 8) Do you awaken with (please circle)
 dry mouth sore throat nasal congestion head aches chest pain disoriented ?
- 9) What time do you awaken in the morning? _____
- 10) Do you snore? YES NO
 (a) How loud is your snoring? _____
 (b) How often does your spouse/bedpartner sleep in another room because of the snoring? _____
- 11) Have you been observed to have pauses in your breathing while asleep? YES NO
- 12) Do you awaken spontaneously or with an alarm clock? _____
 - Do you frequently use the snooze button to extend your sleeping time? YES NO
- 13) Do you awaken feeling refreshed or fatigued? _____
- 14) Do you consume caffeinated beverages during the day, when and how much? _____
- 15) Do you feel sleepy during the day? YES NO
- 16) Do you take naps during the day or before going to bed? YES NO
 -If so how long and is there a particular time of day? _____
- 17) Have you had a prior sleep study? YES NO
 - What did it show? _____
- 18) Do you have dreams often in your sleep? YES NO

19) To rate your degree of sleepiness during the day please respond to the following:

How likely are you to *doze off or fall asleep* during the day in the following situations, in contrast to feeling just tired?

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

<u>Situation</u>	<u>Chance of dozing</u>			
Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (i.e. theater)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

- 19) Do you have pets in your house? YES NO
 18a) Do they ever sleep in your bed? When? _____
- 20) Do you have down or feather pillows, comforter, mattress pad? _____

THANK YOU FOR YOUR TIME.