Woodlands Premier Sleep Center

# SLEEP QUESTIONNAIRE

Name: _____ Date: _____ Location: _____

Referring Physician: _____ Primary Physician: _____

Height: ___ ft. ___ in. Weight: _____ lbs. Neck size: _____ DOB: _____ Age: _____ Sex: _____

Occupation: _____ Usual Work Hours/Days _____

**Please circle marital status:** Single Married Divorced Widowed

*Please complete the following questionnaire by filling in the blanks and placing a check in the appropriate areas.*

## Chief Complaint

**Unwanted behaviors during the night? Please explain:** _____

**Other, explain:** _____

_____

## Sleep Patterns

| | Work Days(Weekday) | Off Days(Weekends) |
|---|---|---|
| **Typical Bedtime** | | |
| **Typical amount of time it takes to fall asleep**? | | |
| **List any awakenings due to i.e., restroom, eating, watching TV etc.?** | | |
| **Typical amount of time to fall back asleep after awakening?** | | |
| **Typical wake up time?** | | |
| **How many times do you wake up in the night?** | | |
| **How do you usually awaken, i.e. alarm clock?** | | |

## Current Medications

_____ _____

_____ _____

_____ _____

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## Habits

**Do you smoke? (circle)** Yes No

| *If Yes:* | What? | Amount per Day | For How Many Years |
|---|---|---|---|
| | Cigarettes | _____ pack(s) | _____ years |
| | Cigars | _____ cigar(s) | _____ years |
| | Tobacco | _____ pipes | _____ years |

**Do you drink alcohol? (circle)** Yes No

| *If Yes:* | What? | Frequency (circle) | Amount per Week |
|---|---|---|---|
| | Beer | Daily Weekends Rare | _____ cans/week |
| | Wine | Daily Weekends Rare | _____ glasses/week |
| | Liquor | Daily Weekends Rare | _____ shots/week |

**Do you drink caffeine? (circle)** Yes No

| *If Yes:* | What? | Frequency (circle) | Amount per Week |
|---|---|---|---|
| | Soda | Daily Weekends Rare | _____ cans/week |
| | Tea | Daily Weekends Rare | _____ glasses/week |
| | Chocolate | Daily Weekends Rare | _____ bars/week |
| | Coffee | Daily Weekends Rare | _____ cups/week |

## Past Sleep Evaluation and Treatment

- ☐ I have had a previous sleep disorder evaluation
- ☐ I have had a previous overnight sleep study
- ☐ I have had a daytime nap study
- ☐ I have been prescribed a CPAP or bi-level PAP machine for home use
- ☐ I have had surgical treatment for a sleep disorder
- ☐ I have previously been prescribed medication for a sleep disorder
- ☐ I have previously been treated for a sleep disorder

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## Sleep History/Habits

| | | | | | |
|---|---|---|---|---|---|
| | witnessed snoring | | fatigued | | pain during the night |
| | witnessed apnea | | lack energy | | sleep walking |
| | perception of choking | | trouble initiating sleep | | short of temper |
| | excessive daytime sleepiness | | trouble staying asleep | | grinding teeth |
| | non refreshed sleep | | trouble concentrating | | night sweats |
| | leg kicks/jerks | | restless/disturbed sleep | | vivid dreams |
| | restless legs | | shift worker | | cataplexy |
| | Drink alcohol before bedtime | | racing thoughts | | fall asleep driving |
| | watch TV in bed | | daytime naps | | hallucinations |

## Medical History

| | | | | | |
|---|---|---|---|---|---|
| | high blood pressure | | hemophilia | | impotence |
| | low blood pressure | | diabetes | | headaches |
| | heart disease | | obesity | | fainting |
| | heart attack | | anxiety | | dizziness |
| | bypass surgery | | depression | | seizures |
| | pacemaker | | psychiatric problems | | hiatal hernia |
| | stroke | | allergies | | reflux |
| | COPD (emphysema/Bronchitis) | | tonsillectomy | | heartburn |
| | asthma | | sinus problems | | ulcers |
| | high cholesterol | | nose fracture | | GERD |
| | arthritis | | nasal surgery | | fibromyalgia |
| | eye trouble | | muscle cramps/weakness | | cancer |
| | hearing trouble | | kidney trouble | | meningitis |
| | tuberculosis | | prostate trouble | | Chronic pain |
| | menopause | | premenstrual syndrome | | hepatitis |
| | thyroid problems | | “black outs” | | Other: |

Please list all surgeries below:

_____

_____

_____