Millennium Physicians
Respiratory & Sleep Disorder Specialists

SLEEP QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____/_____/_____

Height:_____ Weight:_____ Bed Partner?: ____ Yes ____ No

Marital Status: ____ Married ____ Single ____ Widow ____ Divorced

1. Main sleep complaints, check all that apply:

- ☐ Loud or disturbing snoring
- ☐ I've been told I stop breathing when I sleep
- ☐ I am tired and sleepy during the day
- ☐ I wake up gasping for air
- ☐ I fall asleep unintentionally
- ☐ I can't fall asleep or stay asleep
- ☐ My limbs jerk or kick at night
- ☐ I have unwanted behavior during sleep. Explain:_____
- ☐ Other:_____

2. How long have you had a sleep problem? _____

3. Have you ever had a sleep study? If so, when? _____

4. CPAP of BIPAP therapy? If yes, what is the current pressure and mask type?
_____

5. Have you gained or lost weight recently? How much? _____

6. What time do you usually:
Go to bed? Weekday: _____ Weekend: _____
Wake up? Weekday: _____ Weekend: _____

7. Do you take naps during the day? _____Yes _____No If yes, how many and how long? _____

8. Do you work rotating shifts? _____**Yes** _____**No**

9. Do you have trouble falling asleep? _____**Yes** _____**No**

10. Do you have trouble staying asleep? _____**Yes** _____**No**

11. Do you have trouble falling back to sleep once awakened? _____**Yes** _____**No**

12. Do you lie in bed with racing/repetitive thoughts? _____**Yes** _____**No**

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13. Do you take medications to help you fall asleep?	_____ **Yes** _____ **No**
14. Do you take stimulants during the day to help you stay awake?	_____ **Yes** _____ **No**
15. Do you suffer from pain that interferes with your sleep?	_____ **Yes** _____ **No**
16. Have you ever been told that you snore?	_____ **Yes** _____ **No**
17. Have you ever been told that you stop breathing in your sleep?	_____ **Yes** _____ **No**
18. Do you wake yourself from snoring, or from choking/gasping for air?	_____ **Yes** _____ **No**
19. Do you suffer from indigestion/heartburn/reflux disease?	_____ **Yes** _____ **No**
20. Do you ever awaken suddenly feeling short of breath?	_____ **Yes** _____ **No**
21. Do you wake up with a dry mouth or sore throat?	_____ **Yes** _____ **No**
22. Do you suffer from morning headaches?	_____ **Yes** _____ **No**
23. Do you sweat at night?	_____ **Yes** _____ **No**
24. Do you feel refreshed and well rested upon wakening?	_____ **Yes** _____ **No**
25. Do you experience leg discomfort such as creepy-crawly or achy sensation that compels you to move your legs or get up and walk?	_____ **Yes** _____ **No**
26. Do your arms or legs jerk/kick in your sleep?	_____ **Yes** _____ **No**
27. Do you grind your teeth while you sleep?	_____ **Yes** _____ **No**
28. Do you have frequent nightmares?	_____ **Yes** _____ **No**
29. Have you ever walked or talked in your sleep?	_____ **Yes** _____ **No**
30. Have you ever injured yourself or a bed partner acting out your dreams while asleep?	_____ **Yes** _____ **No**
31. Do you experience vivid-like dreams soon after falling asleep or close to waking up?	_____ **Yes** _____ **No**
32. Have you ever found yourself unable to move or paralyzed for a short time upon falling asleep or awakening?	_____ **Yes** _____ **No**
33. Have you every experienced sudden muscle weakness during vigorous laughter when angry?	_____ **Yes** _____ **No**
34. Have you ever experienced sleep attacks or sudden onset of severe drowsiness?	_____ **Yes** _____ **No**
35. Do you suffer from allergies?	_____ **Yes** _____ **No**
36. Do you suffer from chronic nasal congestion?	_____ **Yes** _____ **No**
37. Do you smoke? If yes, how much?	_____ **Yes** _____ **No**

38. Have you ever had nasal or sinus surgery? If yes, when? _____

39. On average, how many alcoholic beverages do you consume in a week? _____

40. On average, how many caffeinated beverages do you consume in a day? _____

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EPWORTH SLEEPINESS SCALE:

41. How likely are you to fall asleep in the following situations?

Sitting and reading:	_____Never	_____Slight	_____Moderate	_____High
Watching television:	_____Never	_____Slight	_____Moderate	_____High
Sitting inactive in a public place:	_____Never	_____Slight	_____Moderate	_____High
As a passenger in a car for 1 hour or more:	_____Never	_____Slight	_____Moderate	_____High
Lying down to rest in the afternoon:	_____Never	_____Slight	_____Moderate	_____High
Sitting and talking to someone:	_____Never	_____Slight	_____Moderate	_____High
Sitting quietly after lunch:	_____Never	_____Slight	_____Moderate	_____High
In a car stopped at a traffic light:	_____Never	_____Slight	_____Moderate	_____High

42. Do you have or are you currently being treated for:

_____ Acid reflux/heartburn
_____ Angina
_____ Anxiety
_____ Asthma
_____ Bipolar disorder
_____ Chronic pain
_____ Chronic nasal congestion
_____ Congestive heart failure
_____ Depression
_____ Diabetes
_____ Drug/alcohol problems
_____ Emphysema/COPD
_____ Frequent Urination
_____ Heart attack
_____ High blood pressure
_____ Irregular heart rhythm
_____ Seizures
_____ Stroke
_____ Thyroid disease

43. Please list any other medical problems:

_____

_____

_____

_____

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Signature:_____ **Date:**_____