SADLER CLINIC
Sleep Disorders Center

Sleep Questionnaire

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Incomplete forms will delay processing. Please fill out ALL questions

Name: _____ **Age:** ____ **Ht:** __ft__ in **Wt:** ___lbs **Date:** _____

Phone Number(s) Hm _____ Wk _____ Cell _____ Birth Date _____ Gender M F

1) Have you ever had a sleep evaluation before? Yes / No If yes, are you currently on **CPAP/BiPAP** treatment? …… Yes No

If you are currently on CPAP or BiPAP then your responses below should be in the context of how you are while using your treatment.

2) What time do you typically go into bed? _____ When do you typically wake up to start your day? _____

3) Do you have difficulty ***falling*** asleep ? Yes / No If yes, about how long does it take to fall asleep? back asleep? _____

If Yes, do you plan your next day while lying in bed trying to fall asleep? ……. Yes No

If Yes, do you have racing thoughts going through your mind while trying to fall asleep?……. Yes No

4) Do you have difficulty ***staying*** asleep ? Yes / No How many awakenings per night? ____ Ave. time to return to sleep? _____

5) Do you take medications to fall or stay asleep? …… Yes No

If yes, name and dose _____

6) Do you feel refreshed when you awaken to start your day? …… Yes No

7) Do you experience an unsettled, ***restless*** sensation in your legs while lying in bed while awake? ……..…..... Yes No

If yes, how often? ____Rarely (25%) ____Half the time (50%) ____Most of the time (75% or more)

If yes, does movement of your legs calm down the restless sensations at least briefly?…… Yes / No

8) Do you have you been told that you kick or twitch your legs while you are asleep? …….. Yes No

9) Do you ***snore*** at night? …….. Yes No

If yes, how would you rate the severity? **Mild** **Moderate** **Severe**

10) Have others told you that you have ***pauses*** in breathing or ***gasping*** sounds while sleeping?……..…… Yes No

If yes, how frequent are the pauses or gasping? __Throughout the night __Frequently __Occasionally

11) Does your bed partner frequently sleep in another room because of how you sleep?……(No bed Partner) ….or ……Yes No

12) Check those that apply to you:

Do you frequently wake up with: __a dry mouth __headaches __excessive sweating __heart burn __chest pain

__ clenching jaws (or grinding teeth) in sleep __ aching in jaws or TMJ pain

__choking or gasping __drooling on the pillow __ bed wetting (loss of bladder control)

__nasal congestion on awakening (which was not present when you went to bed)

13) Do you have unusual behaviors in your sleep?……. Yes No

If yes, how often? _____ When did this start to occur? _____

If yes, briefly describe what you do in your sleep:_____

If yes, what part of the night do these typically occur? Within the first **90** minutes, **first 3 hrs** **last 3 hrs** of sleep?

14) Do you have difficulty maintaining concentration during the day? …… Yes No

15) Are you ***sleepy*** during the day? …… Yes No

16) Do you take naps often? ……..…… Yes No

If yes, for how long? _____ Do you usually dream during these naps? …… Yes No

17) Daily consumption of: Caffeinated beverages? ____ Alcoholic drinks? ____ Tobacco Products? ____

18) Do you occasionally awaken feeling ***paralyzed***? ……..…… Yes No

19) Do you experience ***sudden loss*** of strength in your legs or arms during the day? ……..… Yes No

If yes, is it brought on by a sudden frightening event or laughter? …… Yes No

Rank how likely it would be for you to become drowsy (like you're going to fall asleep) during the day in the following situations--in contrast to feeling just tired in the following situations?

0 = never become drowsy 1 = Rarely become drowsy 2 = frequently become drowsy 3 = always become drowsy

Chance of Becoming Drowsy				Situations
0	1	2	3	Sitting and reading
0	1	2	3	Watching TV
0	1	2	3	Sitting, inactive in a public place (e.g. 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

USE A SEPARATE SHEET OF PAPER IF NEEDED TO ANSWER THE QUESTIONS BELOW

My sleep problems are:

My other medical problems are:

My medications are:

Have you had a sleep study before? Yes No

If so then When and Where? _____Can you get report? Yes No

Have you had surgery for sleep apnea before? Yes No

Do you need assistance at night by other people? Yes No

Do you have COPD? Yes No Use Oxygen at night? Yes No ___L/min

Who filled out this questionnaire? _____

Referring Physician _____

Physician Phone Number _____

Insurance _____