Sleep Disorder Questionnaire

Print Name _____ **Date** _____

1. Why are you seeking treatment at this time? _____

   _____

   _____

2. Is there any aspect of your sleep environment that seems to contribute to your sleep problems, if yes, explain:

   _____

   _____

3. What is your neck size? _____
4. What is your usual bedtime (time you get into bed)? _____
5. What is your usual rise time (the time you get out of bed)? _____
6. Does your bedtime and rise time fluctuate from day to day? _____
7. Do you change your bedtime and rise time on the weekends or on days that you do not work? ..... Yes No

   If yes, what is your usual bedtime on weekends or non-work days? _____

   What is your usual rise time on weekends or non-work days? _____
8. How long does it usually take you to fall asleep after you get into bed? _____
9. How many times to you usually awaken during the sleep period? _____
10. What is the average duration of your awakenings? _____
11. On average, how long would you say you actually are asleep each night? _____
12. Do you have a regular nightly routine you follow every night before getting into bed, if yes, explain: _____

    _____

    _____

13. Do you read, watch tv or engage in other activities while in bed before sleep onset, if yes, explain: ..... Yes No

    _____

    _____

14. Do you usually feel sluggish, sleepy or fatigued upon awakening in the morning? ..... Yes No
15. Do you usually feel fatigued throughout the day? ..... Yes No
16. Do you have difficulty functioning at work due to fatigue? ..... Yes No
17. Do you tend to fall asleep at inappropriate times? ..... Yes No

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18.	Have you had a motor vehicle accident due to sleepiness or fatigue?	Yes	No
19.	Do you usually nap during the day?	Yes	No
20.	Do you usually have difficulty falling asleep at the beginning of the sleep period?	Yes	No
21.	Do you wake up too early and find that you can't return to sleep?	Yes	No
22.	Do you snore?	Yes	No
23.	Have you awakened yourself or someone else with snoring sounds?	Yes	No
24.	Has anyone ever told you, you seem to have difficulty breathing or that you stop breathing during sleep?	Yes	No
25.	Do you ever awaken with the sensation of shortness of breath?	Yes	No
26.	Do you ever awaken gasping, choking or "gulping for air"?	Yes	No
27.	Do you often awaken with a dry mouth or sore throat?	Yes	No
28.	Do you ever awaken with headaches?	Yes	No
29.	Have you had surgery for snoring or sleep apnea?	Yes	No
30.	Have you ever experienced "sleep attacks" (sudden irresistible urge to sleep?	Yes	No
31.	Upon falling asleep or waking up have you ever had the experience of being unable to move your arms or legs, even if you try?	Yes	No
32.	Have you ever done things during the day without having awareness of your actions?	Yes	No
33.	Have you ever experienced sudden muscle weakness while awake (in mild conditions this could be experienced as a week grip or leg or arm weakness)? In severe conditions, one's legs might buckle and the person might fall to the floor?	Yes	No
34.	Do you experience painful or unusual sensations in your legs while at rest, especially in the evening?	Yes	No
35	Do you ever experience "twitching" or "jerking" of your feet or legs while asleep?	Yes	No
36.	Are you a shift worker (evenings, nights or rotating shifts)?	Yes	No
37.	Do you suffer from jet lag?	Yes	No
38.	Do you find that you typically fall asleep earlier than desired and awaken earlier than desired?	Yes	No
39.	Do you find that you typically fall asleep later than desired and awaken later than desired?	Yes	No
40.	Have you now, or have you ever in the past, received treatment for high blood pressure?	Yes	No
41.	Have you been told that you have an irregular heartbeat (cardiac arrhythmia)?	Yes	No
42.	Have you ever suffered a stroke?	Yes	No
43.	Have you ever suffered a heart attack?	Yes	No