Paloma Medical Group

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SLEEP DISORDERS CENTER

CONFIDENTIAL SLEEP QUESTIONNAIRE

Patient's Name: _____ **DoB:** _____/ _____/ _____

Age: _____ Gender: ☐ Male ☐Female Height: _____ inch Weight: _____ lbs Neck Size: _____

Please describe your sleep problem for which you are here today:_____

_____

How long have you this problem?

☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ more than 6 months ☐ 1 year or more

How often do you experience this problem?

☐ 1-2 times per week ☐ 3-5 times per week ☐ every night

How would you rate the current condition of this problem?

☐ Staying the same ☐ Getting better ☐ getting worse

Have you and your bed partner had to sleep separately due to this problem?

☐ Yes ☐ No If yes, for how long _____

Have you had prior sleep studies or evaluation for this problem? ☐ Yes ☐ No
Have you received any prior treatment for this problem? ☐ Yes ☐ No

If yes, please mentioned the date, place/facility the study/evaluation was done: -

_____

What treatment you have received? _____

SLEEP SCHEDULE AND HYGIENE

What is your occupation? _____ Do you work shift work? ☐ Yes, *please explain* _____ ☐ No
Do you have trouble sleeping when you are doing shift work? ☐ Yes ☐ No
What is your bedtime? _____ p.m. / a.m. Is your bedtime: ☐ Same everyday
☐ Depends on (*please describe*): _____
☐ Varies (*please describe*): _____
How many hours do you usually sleep on **weekdays** or days that you work? _____
How many hours do you usually sleep on **weekends** or day that you do not work? _____
How long does it take you to go to sleep? Mins/hours _____

How many times do you **awaken** during the night? _____

How many times do you **get up to use the bathroom** at night? _____

What time do you get up on **workdays** and **weekends**? _____ a.m./p.m. _____ a.m./p.m.

Comfortable sleeping position is:

☐ On side ☐ on back ☐ on stomach ☐ in bed with head elevated ☐ in a chair or recliner

How do you feel when you wake up from regular sleep time?

☐ Well rested/refreshed ☐ somewhat rested ☐ same as bedtime ☐ tired

Do you nap or doze during the day? ☐ Yes ☐ No How long is your nap in the AM? _____ mins/hours

Are any of these naps intentional? ☐ Yes ☐ No How long is your nap in the PM? _____ mins/hours

If you nap or doze during the day, how do you feel when you wake up?

☐ well rested/refreshed ☐ somewhat rested ☐ same as bedtime ☐ Tired

Do you read in bed? ☐ Yes ☐ No Do you watch TV in bed? ☐ Yes ☐ No

Do you write in bed? ☐ Yes ☐ No Do you eat in bed? ☐ Yes ☐ No

Do you worry in bed? ☐ Yes ☐ No Do you have arguments in bed? ☐ Yes ☐ No

INSOMNIA

Do you often have trouble **getting to sleep** at night? ☐ Yes ☐ No

What is the **average number of minutes** it take you to fall asleep at night? _____ mins

Do you often have **awakening** during the night? ☐ Yes ☐ No

If yes, what is the **average number of times** per night that you wake up? _____

If yes, why do you **wake up**? _____

Do you have long periods when you awaken and are not able to get back to sleep? ☐ Yes ☐ No

If yes, how long are these periods of wakefulness when added together? _____ minutes per week

Are you bothered by waking up too early and not being able to get back to sleep? ☐ Yes ☐ No

If yes, what is the average number of nights per week? _____

Do you use any drugs or medications to aid with sleep? ☐ Yes ☐ No

List medications: _____

How many times per week do you used these? _____

MOVEMENT

Are your bed covers "**messy**" in the morning when you wake up? ☐ Yes ☐ No

Do you awaken yourself by **kicking your legs** during the night? ☐ Yes ☐ No

Has your **bed partner ever complained** of your legs kicking during the night? ☐ Yes ☐ No

Do you have a restless sense of **discomfort in your legs** during the waking hours? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

PARASOMNIAS

Did you have a **sleep problem as a child**? ☐ Yes ☐ No If yes, explain: _____

Do you currently have **nightmares or night terrors?** ☐ Yes ☐ No

If yes, how frequently? _____ (per week/ month/year) If yes, at what age did they begin? _____

Do you **grind or clench** your teeth at night? ☐ Yes ☐ No

Did you **wet the bed** as a child? ☐Yes ☐No If yes, for how many year? _____
Have you ever **wet the bed** as an adult? ☐Yes ☐No
Have you ever been told that you **walk in your sleep?** ☐Yes ☐No
Have you even told that you make **unusual movements** other than leg kicking during sleep? ☐Yes ☐No

EXCESSIVE SLEEPINESS

Do you **feel excessively sleepy** in the daytime? ☐Yes ☐No
If yes, how long has this occurred for? _____ months/years

Have you ever had an **accident or near miss accident** because of falling asleep while driving? ☐Yes ☐No
If yes, please explain: _____

How often do you **snore**?
☐Never ☐Rarely ☐Occasionally ☐Frequently ☐Always
If you do, for how many : _____ years and or months
How often does **sleep position affects your snoring**?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always
In which position do you **snore most loudly?**
☐back ☐right side ☐left side ☐stomach ☐other
How often have you been told that you **stop breathing** during sleep?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always
How often do you wake up with **morning headaches**?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always
How often do you awaken with a **dry mouth or sore throat**?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always
How often are you **confused in the morning**?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always
How often do you have **night sweats**?
☐Never ☐rarely ☐Occasionally ☐Frequently ☐Always

Please recall you weight history if applicable:
Weight at 20 _____ lbs. Weight at 30 _____ lbs. Weight at 40 _____ lbs.
Weight at 50 _____ lbs. Weight at 60 _____ lbs. **Heaviest Weight** _____ lbs. at _____ years of age

If you have gained weight, do you feel that you sleepiness is associated with it? ☐Yes ☐No
Have you ever had any exceptionally **vivid dreams** just as you were falling asleep or waking up? ☐Yes ☐No
If yes, please describe: _____
How often? ☐Yearly ☐Monthly ☐weekly ☐nightly

Have you ever felt paralyzed for a few seconds as you awaken? ☐Yes ☐No If yes, how often? _____
If yes, how often? ☐Yearly ☐monthly

Have you experienced episodes of **muscle weakness, loss of muscle strength, or limp muscles** in any part of your body during the following situations?
When you laugh? ☐Yes ☐No When you are angry? ☐Yes ☐No
When hearing or telling a joke? ☐Yes ☐No
Just as you are dozing off or immediately upon awakening, do you ever **hallucinate**? ☐Yes ☐No

Signature: _____ Date: _____