THE CENTER FOR sleep & wake DISORDERS

Sleep Questionnaire

5454 Wisconsin Avenue, Suite 1725, Chevy Chase, MD 20815

Please complete the following questionnaire and bring it with you to your appointment.
If you have any questions, please call (301) 654-4333.

Name_____ Date_____

Home address_____

_____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Phone number _____ Are you: Right Handed ☐ Left Handed ☐

Referring Physician _____

Describe why you have been referred to The Center for Sleep & Wake Disorders:

_____

_____

_____

Have you ever been evaluated for a sleep problem? ..... *Yes* *No*

If yes, please describe:_____

_____

Be sure to locate and bring results of prior sleep studies/workup with you.

How long have you had your sleep problem? _____

Falling Asleep:

How great a problem do you have falling asleep 0 1 2 3 4 5

What time do you usually get into bed on weekdays _____ weekends _____

How long after getting into bed do you decide to go to sleep _____

How long does it take you to fall asleep _____

How many hours of ***sleep*** do you get on an average night _____

While falling asleep do you ever:

Feel unable to move (paralyzed) ..... yes no

Notice that parts of your body startle or jerk ..... yes no

Experience restless legs (or irresistable urge to move legs) ..... yes no

Experience vivid dream-like scenes even though you know you are awake ..... yes no

Experience any kind of pain or discomfort ..... yes no

If yes, please describe the pain or discomfort_____

_____

Asleep:

Is your sleep disturbed by:

Asthma ..... yes no

Chronic nocturnal cough ..... yes no

Grinding your teeth ..... yes no

Heartburn/ Reflux ..... yes no

Nasal congestion ..... yes no

Difficulty breathing ..... yes no

Holding your breath ..... yes no

Gasping for breath ..... yes no

Snoring ..... yes no

If yes, is your snoring disruptive to others ..... yes no

Sleep walking ..... yes no

Talking in your sleep ..... yes no

Sweating ..... yes no

Heart pounding in your chest ..... yes no

Falling out of bed ..... yes no

Need to urinate ..... 0 1 2 3 4 5 times

Bed wetting ..... yes no

Headache ..... yes no

Frequent Nightmares ..... yes no

Thrashing movements ..... yes no

Frequent Muscle cramps ..... yes no

Leg twitching/restless legs ..... yes no

Have you ever injured or almost injured yourself or your bedpartner while you were asleep?
Yes No *If yes,* please describe the incident(s) _____

_____

_____

Describe any other problems you have during sleep _____

_____

Night Awakenings:

How many times do you awaken during the night _____

How long does each awakening usually last _____

What is the total time that you are awake during the night _____

Why do you awaken during the night _____

_____

Morning:

What time do you awaken in the morning on weekdays _____ weekends _____

Do you have difficulty awakening in the morning ..... yes no

Have you ever been unable to move when you awaken ..... yes no

Do you cough up sputum upon awakening ..... yes no

Do you wake up with a morning headache ..... yes no

Do you awaken from sleep screaming, violent or confused ..... yes no

If yes, what exactly do you experience _____

_____

_____

Daytime:

(Circle 0 if you do not)

Do you have a problem with daytime sleepiness 0 1 2 3 4 5

No matter how much you sleep do you still feel tired 0 1 2 3 4 5

If sleepy, how likely are you to doze off or fall asleep in the following situations?
0=*never,* ***1****= slight,* ***2****= moderate,* ***3***=*high* ***(Circle one response)***

Sitting & reading	0	1	2	3
Watching TV	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for an hour	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting & talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Have you ever fallen asleep:

during intercourse ..... yes no

while eating ..... yes no

while on the telephone ..... yes no

while in conversation with others ..... yes no

while driving a motor vehicle ..... yes no

if so, describe any accidents that have resulted _____

In what other settings have you fallen asleep _____

_____

Napping: Actually falling asleep for five minutes or more

Do you nap on weekdays? yes ..... no ..... How many days per week? .....

How many naps/day_____ Average length/nap _____ min. Total nap time/day _____

What time(s) do you nap_____

Do you feel refreshed after a nap (**Circle one response)** *Very Moderately A little Not at all*

Are naps planned? _____

Do you have vivid dreams during naps..... yes no

Have you ever awakened from a nap unable to move ..... yes no

Do you ever nap for less than five minutes ..... yes no

If yes, please describe _____

Describe any naps you take on weekends: _____

_____

Past Medical History:

List any current or previous medical problems, with special attention to hypertension, lung, heart or nervous system diseases:

_____

_____

Please describe any current or previous psychiatric problems, including treatment and hospitalization:

_____

Recent stressors: _____

List all surgical procedures: _____

_____

Please describe any head injuries associated with loss of consciousness.

_____

Have you ever had a seizure ..... yes no

I*f yes,* please elaborate: _____

Do you suffer from dizzy spells ..... yes no

Have you ever had the sensation of weak knees when you laugh ..... yes no

Have you ever fallen limp to the ground when excited without losing consciousness or fainting yes no

Have you had a greater than 10 pound change in body weight ..... yes no

Weight gain? *yes* *no* how much? _____ Year____

Weight loss? *yes* *no* how much? _____ Year____

Have you ever been diagnosed with a learning disability or hyperactivity disorder? *Yes / No*

Describe any treatment _____

Describe any family history of major illness, sleep disorders, or neurological disease:

mother: _____

father: _____

siblings: _____

other relatives: _____

Describe any psychiatric illness in family members:

_____

_____

If you never smoked check here _____ and skip the rest of the smoking questions.
If you are a current smoker: Packs per day _____ How many years _____
How often do you smoke within two hours of bedtime_____
If you quit, when? _____ Prior smoking history: packs/day _____ years _____

How many **cups/day** do you drink of:

Caffeinated Coffee/Tea _____ *Caffeinated Soft Drinks* _____

How much beer, wine or liquor do you drink **per week**_____

Do you regularly drink a caffeinated or alcoholic beverage within two hours of bedtime? yes / no

Do you exercise? yes / no How many hours/week _____ what exercise _____

List all current medications (including any over-the-counter remedies)

_____

_____

_____

What medications do you take to help you sleep now_____
In the past : _____

What medications do you take to help you stay awake _____

List all drug allergies and reactions _____

What was your birth weight _____ Were you a twin or triplet? yes / no

Were there any unusual conditions of your mother's pregnancy or your delivery
(prolonged labor, forceps, blue baby, etc.) _____

What is your present occupation _____

What hours do you work _____

Feel free to add a page to elaborate on any answers. Thank you.

Please bring copies of prior sleep studies with you to your appointment.