



A Teaching Affiliate of the University of Miami Miller School of Medicine at FAU

SLEEP DISORDERS CENTER
SLEEP QUESTIONNAIRE

Patient Name: Sex: Age: Date:

Occupation: Usual Work Hours/Days:

Referring Physician: Family Physician (PCP):

Marital status: Single Married Divorced Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

- Trouble sleeping at night For how many months/years?
Being sleepy all day For how many months/years?
Snoring For how many months/years?
Unwanted behaviors during sleep, explain
Other, explain

Sleep Pattern

Table with 2 columns: Work Days (Weekday), Off Days (Weekends). Rows include: Typical bedtime, Typical amount of time it takes to fall asleep, Typical number of awakenings per night, List any activities that you normally do during nighttime awakening(s), Typical amount of time to fall back asleep after an awakening, Typical wake up time, Desired wake up time.

How do you usually awaken,  
i.e., alarm clock?: \_\_\_\_\_

Typical time you get out of bed: \_\_\_\_\_ a.m./p.m. \_\_\_\_\_ a.m./p.m.

Total amount of sleep per night: \_\_\_\_\_

Number of naps per day: \_\_\_\_\_

Please check all of the following statements that are true about your sleep:

**Sleep Habits**

- I usually watch TV or read in bed prior to sleep
- I often travel across 2 or more time zones
- I drink alcohol prior to bedtime
- I smoke prior to bedtime or when I awaken during the night
- I eat a snack at bedtime
- I eat if I wake up during the night
- I typically wake up from sleep to go to the bathroom
- I have trouble falling asleep
- I often wake up during the night
- I am unable to return to sleep easily if I wake up during the night
- I have thoughts that start racing through my mind when I try to fall asleep
- I wake up early in the morning, and I am still tired but unable to return to sleep
- I have nightmares as an adult
- I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- I sweat a great deal during sleep
- I cannot sleep on my back

**Breathing**

- I have been told that I stop breathing while I sleep
- I wake up at night choking, smothering or gasping for air
- I have been told that I snore
- I have been told that I snore only when sleeping on my back
- I have been awakened by my own snoring

**Restlessness**

- I have uncomfortable feelings in my legs and/or arms when I lie down at night
- I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- I am a restless sleeper
- I have been told that I kick or jerk my legs and/or arms during sleep
- I have a hard time falling asleep because of my leg movements
- I have talked in my sleep as an adult
- I have walked in my sleep as an adult
- I grind my teeth in my sleep

**Daytime Sleepiness**

- I take daytime naps
- I have a tendency to fall asleep during the day
- I have had “blackouts” or periods when I am unable to remember what just happened

- I have fallen asleep while driving
- I have had auto accidents as a result of falling asleep while driving
- I fall asleep while watching TV
- I fall asleep during conversations
- I fall asleep in sedentary situations
- I performed poorly in school because of sleepiness
- I have had injuries as the result of sleepiness
- I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- I have had an inability to move while falling asleep or when waking up
- I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- I drink caffeinated beverages during the day: \_\_\_\_\_ cups/bottles/cans per day

**Habits**

Do you smoke?  Yes  No

<i>If Yes:</i>	<u>What?</u>	<u>Amount per Day</u>	<u>For How Many Years</u>
<input type="checkbox"/>	Cigarettes	_____ pack(s)	_____ years
<input type="checkbox"/>	Cigars	_____ cigars	_____ years
<input type="checkbox"/>	Tobacco	_____ pipes	_____ years

Do you drink alcohol?  Yes  No

<i>If Yes:</i>	<u>What?</u>	<u>Frequency</u>	<u>Amount per Week</u>
<input type="checkbox"/>	Beer	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ cans/week
<input type="checkbox"/>	Wine	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ glasses/week
<input type="checkbox"/>	Liquor	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ shots/week

**Social History**

- Sleep alone
- Share a bed with someone
- Share a bedroom, but have separate beds
- Share a dwelling, but have separate bedrooms

Employment Status:  Employed  Unemployed  Retired

- My job requires driving a vehicle
- I work with dangerous equipment or substances
- I am a shift worker on rotating shifts
- I am a permanent or long-term, third-shift worker
- I am currently a student

**Medical History**

**Vital Statistics**

What is your: Height? \_\_\_\_ feet \_\_\_\_ inches Weight? \_\_\_\_\_ pounds Neck Size: \_\_\_\_\_

What was your weight one year ago? \_\_\_\_\_ pounds Five years ago? \_\_\_\_\_ pounds

**Current Medications**

<u>Medication</u>	<u>Dose</u>	<u># Times per Day</u>	<u>Medication</u>	<u>Dose</u>	<u># Times Per Day</u>
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**Allergies:** \_\_\_\_\_

**Past Sleep Evaluation and Treatment**

- I have had a previous sleep disorder evaluation
- I have had a previous overnight sleep study
- I have had a daytime nap study
- I have been prescribed a CPAP or bilevel PAP machine for home use
- I have had surgical treatment for a sleep disorder
- I have previously been prescribed medication for a sleep disorder
- I have previously been treated for a sleep disorder

**Past Medical History**

- |   |   |
|---|---|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hepatitis/jaundice             |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Hearing impairment             |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Depression or severe anxiety   |
| <input type="checkbox"/> Stomach or colon problems          | <input type="checkbox"/> Alcoholism                     |
| <input type="checkbox"/> Lung problems/COPD/asthma          | <input type="checkbox"/> Chemical dependency or abuse   |
| <input type="checkbox"/> Reflux                             |   |
| <input type="checkbox"/> Fibromyalgia                       | <b><u>Female</u></b>                                    |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Premenstrual syndrome          |
| <input type="checkbox"/> TIA "Light Stroke"                 | <input type="checkbox"/> Menopause                      |
| <input type="checkbox"/> Blackouts                          |   |
| <input type="checkbox"/> Seizures                           | <b><u>Male</u></b>                                      |
| <input type="checkbox"/> Back or joint problems (arthritis) | <input type="checkbox"/> Prostate problems              |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Erectile dysfunction/impotence |
| <input type="checkbox"/> Thyroid problems                   |   |

**List other past medical problems and dates:**

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When falling asleep, I have restless legs (creepy-crawly feelings, aching, or inability to keep legs still)	1	2	3	4	5
If I wake up during the night, I have trouble getting back to sleep because of restless legs or leg movements	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breathe	1	2	3	4	5
At night my heart pounds, beats rapidly, or beats irregularly	1	2	3	4	5
I sweat a great deal at night	1	2	3	4	5
My sleep is disturbed by sadness or depression	1	2	3	4	5
I have a lot of nightmares (frightening dreams)	1	2	3	4	5
I feel unable to move (paralyzed) after a nap	1	2	3	4	5
I have dream-like images (hallucinations) as I wake up in the morning, even though I know I am not asleep	1	2	3	4	5
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	1	2	3	4	5
I have been unable to sleep at all for several days	1	2	3	4	5
I feel that I have insomnia	1	2	3	4	5
I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
I got bad grades in school because I was too sleepy	1	2	3	4	5
<b><u>Answer Key</u></b> 1 – Never (Strongly disagree)		2- Rarely (Disagree)	3 – Sometimes (Not sure)	4 – Usually (Agree)	5 – Always (Agree strongly)
In the past 6 months I have fallen asleep while eating, talking to someone, riding in a bus or car, reading a book, watching TV or a movie, or listening to a lecture	1	2	3	4	5
I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
I often have to let someone else drive the car because I am too sleepy to drive	1	2	3	4	5
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	1	2	3	4	5
I often am unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
Sometimes I realize I have driven my car to the wrong place, and	1	2	3	4	5

I can't remember how I did it					
I get "weak knees" when I laugh	1	2	3	4	5
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion	1	2	3	4	5
I have high blood pressure (or once had it)	1	2	3	4	5
My desire or interest in sex is less than what it used to be	1	2	3	4	5
I am unhappy about loving relationships in my life	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
I smoke tobacco within two hours before bedtime	1	2	3	4	5
I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	1	2	3	4	5
My snoring or my breathing problem is much worse if I sleep on my back	1	2	3	4	5
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	1	2	3	4	5



SLEEP DISORDERS CENTER
BED PARTNER QUESTIONNAIRE

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Check any of the following behaviors that you have observed the patient doing while asleep:

- Checkboxes for behaviors: Loud snoring, Light snoring, Twitching of legs or feet, Pauses in breathing, Grinding teeth, Sleep talking, Sleepwalking, Bedwetting, Sitting up in bed while still asleep, Head rocking or banging, Kicking with legs, Getting out of bed while still asleep, Biting tongue, Becoming very rigid and/or shaking.

How long have you been aware of the sleep behavior(s) that you checked above?

Four horizontal lines for writing the duration of awareness.

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

Five horizontal lines for describing the behavior in detail.

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

Five horizontal lines for describing loud snoring in detail.



