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**Sleep Laboratory**

# PATIENT QUESTIONNAIRE

Name: _____ Birthdate: _____ Age: _____

Height: _____ Weight: _____ ☐Male ☐Female

**HAVE YOU EVER BEEN DIAGNOSED WITH: (check off yes or no)**

High Blood Pressure ☐Yes ☐No

Heart Attack ☐Yes ☐No

Asthma, Emphysema, Chronic Bronchitis ☐Yes ☐No

Stroke ☐Yes ☐No

Congestive Heart Failure ☐Yes ☐No

Do you require a wheelchair? ☐Yes ☐No

If yes, are you able to transfer from your chair to a bed? ☐Yes ☐No

Are you under the care of a doctor for any serious illness? ☐Yes ☐No

If yes, what is the illness? _____

Briefly describe help and support that family and friends give you in dealing with your illness:

_____

List any other type of help or support that you would like to receive from family and friends:

_____

Do you feel unsafe in your home? ☐Yes ☐No

If yes, why: _____

Are you on oxygen? ☐Yes ☐No

If yes, what liter flow? _____ ☐24 hours a day ☐Only at night

**What prescription medications to you use? (attach list if available)**

_____

_____

Do you smoke? ☐Yes ☐No

If yes, ☐cigarettes ☐cigars ☐pipe ☐How much? _____

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, do you drink:

☐5 or more drinks a day ☐1-4 drinks a day

☐2-3 drinks a week ☐1-3 drinks a month

What hours do you work? _____
What time do you normally go to bed? _____
What time do you normally awaken to begin your day? _____
How long does it usually take you to fall asleep? _____
How many hours a night do you normally sleep? _____
How many hours of sleep do you normally need to feel rested? _____

| | | |
|---|---|---|
| Have you been told you kick or jerk legs while sleeping? | ☐Yes | ☐No |
| Have you been told you snore? | ☐Yes | ☐No |
| Have you been told you stop breathing at night? | ☐Yes | ☐No |
| Do you have creepy, crawling or aching feeling in your legs (feel like you have to move them? | ☐Yes | ☐No |
| Do you have leg pain or cramps during the night? | ☐Yes | ☐No |
| Do you need to move legs at night to feel comfortable? | ☐Yes | ☐No |

**FOR EACH OF THE FOLLOWING QUESTIONS, CHECK OFF THE LETTER THAT MOST ACCURATELY DESCRIBES THE CLOSEST FREQUENCY USING THE FOLLOWING GUIDE:**

**Never =** 1 night a month or less **Rarely** = 1-4 nights a month
**Often** = 2-5 nights a week **Always** = 6-7 nights a week

| | Never | Rarely | Often | Always |
|---|---|---|---|---|
| How often do you have trouble falling asleep? | ☐ | ☐ | ☐ | ☐ |
| When this happens, do you: | | | | |
| Feel worried or depressed? | ☐ | ☐ | ☐ | ☐ |
| Feel physical pain or discomfort? | ☐ | ☐ | ☐ | ☐ |
| Use alcohol to fall asleep? | ☐ | ☐ | ☐ | ☐ |
| Use over-the-counter medications to fall asleep? | ☐ | ☐ | ☐ | ☐ |
| Use prescribed medications to fall asleep? | ☐ | ☐ | ☐ | ☐ |

If YES, what medications do you use:

_____

| | Unknown | Never | Rarely | Often | Always |
|---|---|---|---|---|---|
| How often do you: | | | | | |
| Grind teeth while sleeping? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walk or talk in sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Have restless sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tear up the covers of your bed during sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Make sudden jerks or movements during sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Have nasal congestion during the night? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Experience excessive sweating while sleeping? | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| Snore loudly? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Snore loudly only while lying on your back? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Snore loudly in all sleep positions? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Snort or gasp for breath? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seem to struggle for breath? | ☐ | ☐ | ☐ | ☐ | ☐ |

Do you awaken during the night to use the bathroom? ☐Yes ☐No

If yes, how many times a night? _____

| | **Never** | **Rarely** | **Often** | **Always** |
|---|---|---|---|---|
| How often do you awaken in the night because of: | | | | |
| Physical pain? | ☐ | ☐ | ☐ | ☐ |
| Heartburn? | ☐ | ☐ | ☐ | ☐ |
| Unknown reason? | ☐ | ☐ | ☐ | ☐ |
| Do you ever awaken: | | | | |
| Choking or gasping for breath? | ☐ | ☐ | ☐ | ☐ |
| With chest pain or heart palpitations? | ☐ | ☐ | ☐ | ☐ |
| During the night with headache? | ☐ | ☐ | ☐ | ☐ |
| In the morning do you awaken: | | | | |
| Still feeling tired? | ☐ | ☐ | ☐ | ☐ |
| Feeling confused or irritable? | ☐ | ☐ | ☐ | ☐ |
| Long before the alarm, unable to return to sleep? | ☐ | ☐ | ☐ | ☐ |
| With headaches? | ☐ | ☐ | ☐ | ☐ |
| Do you need an alarm to wake up? | ☐ | ☐ | ☐ | ☐ |
| Do you ever feel weak when you laugh, cry or are excited? | ☐ | ☐ | ☐ | ☐ |
| Do you have vivid dreams soon after falling asleep? | ☐ | ☐ | ☐ | ☐ |
| Do you feel unable to move, yet mentally alert? | ☐ | ☐ | ☐ | ☐ |
| Have you ever had episodes of feeling paralyzed during sleep? | ☐ | ☐ | ☐ | ☐ |
| Have you ever had “sleep attacks” during the day? | ☐ | ☐ | ☐ | ☐ |
| Do you feel your memory getting worse? | ☐ | ☐ | ☐ | ☐ |
| Do you find it harder to concentrate? | ☐ | ☐ | ☐ | ☐ |

**HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO FEELING JUST TIRED? USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION AND WRITE THAT NUMBER ON THE LINE.**

0 = Never 1 = Slight 2 = Moderate 3 = High

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. church, theatre) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon, when possible _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

**TOTAL** _____

**0 – 9 Average score, normal population**

Have you noticed anything else about your sleep that was not covered by this questionnaire?