

MANKATO CLINIC



J. SCOTT SANDERS
CENTER FOR SLEEP MEDICINE

SLEEP QUESTIONNAIRE

Name: _____ Date Completing Form: _____

Date of Birth: _____ Age: _____ Male Female

Height: _____ Weight: _____ lbs

Current Medical Conditions: _____

Primary concern with sleep: _____

How many nights a week does this occur? _____

How long have you been experiencing this problem? _____

Have you had a sleep study in the past? _____ Date: _____ Where: _____

What was the outcome? _____

What time do you usually go to bed? _____ a.m./p.m.

What time do you get up on a work day? _____ a.m./p.m.

What hours do you work: Days Afternoons Nights Rotational

If you work rotational hours, what is your rotation schedule? _____

If you ever consistently worked afternoons or night shifts, when did you last work these shifts? _____

Does your bedtime differ on weekends? _____

If yes, what time do you go to bed: _____ a.m./p.m.

What time do you get up for the day on weekends? _____ a.m./p.m.

Do you regularly have difficulty falling sleep? No Yes

On average, how long do you think it takes for you to fall asleep? _____ minutes/hours

Do you have trouble with waking up during the night? No Yes
If yes, answer the following questions:
How many times? _____
Are you able to return to sleep? _____

Do you set an alarm clock? No Yes
Do you get up as soon as the alarm goes off? No Yes

Do your sleep difficulties bother your bed partner? No Yes
Do you have pets that sleep in your bed or room? No Yes
Do they wake you? No Yes

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

Do you worry before falling asleep? No Yes
Do you find it difficult to 'shut off' your mind? No Yes

Is your bedtime fairly regular? No Yes
Do you wake feeling refreshed? No Yes
Have you ever fallen asleep while driving?
If yes how long ago? _____

Have you ever fallen asleep at a stop sign? No Yes
Have you ever stopped driving to nap?
If yes how many times in the past year? _____
Do you fall asleep if you are a passenger? No Yes

Do you nap during the day? No Yes
If yes for how long? _____
Do you feel refreshed from the nap? No Yes

If you could set your own sleep schedule, what time would you go to bed? _____
What time would you get up? _____

Do you exercise on a regular basis? No Yes
If yes, what time of day do your exercise? _____ a.m. / p.m.
What type of exercise? _____
How often in an average week do you exercise? _____

Describe what your bedding looks like when you wake up in the morning:

Has anyone ever mentioned that you move your legs, kick, or jerk during night? No Yes

Do you ever have an uncomfortable, restless, crawling sensation in your legs? No Yes

Do you have a problem sitting still in a movie, meeting, or watching TV? No Yes

Do you ever have leg cramps? No Yes

What do you do to relieve the cramps or the restless feeling? _____

Do any of your siblings or your parents have restless legs? No Yes

Do any of them snore? No Yes

Do any sleep walk or talk? No Yes

Do any of them experience nightmares? No Yes

Does anyone in y our family have sleep apnea? No Yes

Please list their relationship to you and their problem(s):

Does anyone you know use a CPAP machine? No Yes

Do you ever wake up feeling like you have been holding your breath or feel like you are choking? No Yes

How often? _____

Has anyone ever told you that you snore? No Yes

Has anyone ever said you stop breathing for short periods while you sleep?

No Yes

Do you sometimes wake up with a headache? No Yes

Do you ever wake up with a dry mouth? No Yes

Do you ever wake up with a sore throat? No Yes

Have you gained weight in the past year? No Yes

How many pounds? _____

Do you feel you have gained weight because your are just too tired to do anything?

No Yes

Has anyone said you have become very 'moody'? No Yes

Do you find it difficult to control your temper more often than in the past?

No Yes

In what position do you prefer to sleep? Back Side Stomach

Have you ever had a broken nose? No Yes

Have you ever had surgery on your nose or throat? No Yes

Have you had your tonsils removed? No Yes

Do you experience frequent heart burn? No Yes

Do you frequently breath through your mouth instead of your nose? No Yes

Do you find it difficult to breath through your nose? No Yes

Do you feel you dream during sleep? No Yes

Do you remember your dreams? No Yes

Do the dreams seem very real? No Yes

Do you often have the same dream over and over? No Yes

Did you have any sleep problems during childhood? No Yes

If yes please list below: _____

Have you ever injured yourself while sleep walking? No Yes
 Do you ever wake yourself up during a dream? No Yes
 Do you fall out of bed on occasion? No Yes
 Have you ever gotten up to eat during the night? No Yes
 Have you ever gotten up in the morning and discovered you perhaps did something during the night, but have no memory of it? No Yes
 If so, how often? _____
 When was the last time this happened? _____

Do you ever wake up with a feeling of fear or panic? No Yes
 Are you sometimes afraid to go to sleep? No Yes
 Are you experiencing more stress than usual at this time? No Yes
 Do you feel you are depressed? No Yes
 Have you been depressed in the past? No Yes
 Have you ever been on medication to help you through a stressful time in your life? No Yes

How long ago? _____
 Do you feel the medication helped? No Yes
 Do you know what the medication was called? _____
 Do you have a problem staying awake at work? No Yes
 Do you find it difficult to drive 100 miles without falling asleep? No Yes
 Do you fall asleep while talking on the telephone? No Yes
 Do you fall asleep while waiting in a doctor or dentist office? No Yes
 Do you ever feel weak, or like you could fall down if you laugh?
 If someone scares you? No Yes
 If you are surprised by something? No Yes
 If you are very angry? No Yes
 Have you ever felt sure someone entered your room as you were falling asleep, but there was no one there? No Yes
 Have you ever heard someone talking to you as you were falling asleep, but there was no one there? No Yes

PLEASE LIST THE MEDICATIONS YOU CURRENTLY TAKE, TIME OF DAY, & DOSAGE

| NAME OF MEDICATION | TIME OF DAY TAKEN | DOSAGE |
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