Mankato Clinic
Together we thrive.

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 <u>consistently</u> 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?_____ (min/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? ☐ No ☐ Yes
If yes how long ago? _____
Have you ever fallen asleep at a stop sign? ☐ No ☐ Yes
Have you ever stopped driving to nap? ☐ No ☐ Yes
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 your 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 your 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 breathe through your mouth instead of your nose? ☐ No ☐ Yes
Do you find it difficult to breathe 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? ☐ No ☐ Yes
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