

Sleep Questionnaire

The information requested below will assist the physician with your medical evaluation. Please fill out this form as legibly as possible. Please bring the completed form with you to your appointment, mail it to our Naples office or fax it directly to us at 239-263-8592 prior to your appointment date. We appreciate your time.

Patient name: _____ Date: _____

All patients please complete the following:

Are you aware that you have a sleep problem? ____ Yes ____ No

If not, who suggested that you seek evaluation? ____ Bed partner ____ Physician ____ Friend or relative
 _____ Other

Briefly describe your sleep problem:

	Yes	No
Do you snore?	_____	_____
Have others complained that you snore?	_____	_____
Has anyone said that you may stop breathing while you sleep?	_____	_____
Are you aware that you stop breathing while you sleep?	_____	_____
Do you ever wake up gasping or choking?	_____	_____
Do you generally wake up tired and sleepy?	_____	_____
Do you experience a loss of energy during the day?	_____	_____
Do you feel fatigue on most days?	_____	_____
Do you usually find it difficult to wake up in the morning?	_____	_____
Do you become tired while driving?	_____	_____
Have you ever fallen asleep while driving or at a stoplight?	_____	_____

	Yes	No
Do you frequently wake up with a dry mouth?	_____	_____
Do you often wake up with a headache?	_____	_____
Do you often wake up sweating at night?	_____	_____
Have your tonsils been removed?	_____	_____
Have you had surgery performed for snoring or sleep apnea?	_____	_____
Have you had indigestion or reflux at night?	_____	_____
Have you had a recent difficulty concentrating?	_____	_____
Have you had recent difficulty with memory?	_____	_____
Do you experience a crawling sensation in the legs at night?	_____	_____
If you do, is the sensation relieved by movement or walking?	_____	_____
Have you been told that you talk or move in your sleep?	_____	_____
Have you been told that your arms or legs kick or move during sleep?	_____	_____
Have you hurt yourself or someone else from body movements at night?	_____	_____
Have you been told that you sleep walk?	_____	_____
Do you wake up from sleep confused or panicked?	_____	_____

All patients must also complete the following page

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to indicate the most appropriate number for each situation. Circle your choice.

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation	Chance of dozing			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg. theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car stopped for a few minutes in traffic	0	1	2	3

Total score (≥ 11 = excessive daytime sleepiness)

Signature: _____

Date: _____

If you *often* have difficulty getting to sleep or staying asleep, complete the following:

When did this problem begin? _____

Do you know what is causing the problem? ____ Yes ____ No

(Details)_____

How many nights a week do you have the problem? ____ (1 -2) ____ (3 – 4) ____ (5 or more)

Yes No

Do you wake up more than once or twice a night? _____

If yes, do you know why you wake up? _____

Do you have more than occasional difficulty getting to sleep? _____

Do you have more than occasional difficulty staying asleep? _____

Does it often take more than 15-20 minutes to get to sleep? _____

Do you often have difficulty getting back to sleep once you wake up? _____

Is your bedroom dark, quiet, and comfortable? _____

Does your bed partner interfere with your ability to sleep? _____

Are your mattress, pillow, and blanket comfortable? _____

Do you have any pets that jump on and off the bed? _____

Do you have infants or young children who interfere with your sleep? _____

Do you also have difficulty with sleep if you are in a hotel or on vacation? _____

What time do you usually go to sleep? _____

What time do you usually wake up for the day? _____

Are these times rigid or variable? ____ Rigid ____ Variable

Do you do shift work? ____ Yes ____ No

How often do you take naps? ____ Never ____ Rarely ____ 3 or more days a week ____ Daily

	Yes	No
Do you often fall asleep after lunch or in the early evening before bedtime?	_____	_____
Do you read or watch television in bed?	_____	_____
If you can't fall asleep or get back to sleep, do you toss and turn in bed?	_____	_____
Is it difficult for you to relax before going to sleep?	_____	_____
Do you have thoughts and concerns that interfere with sleep?	_____	_____
Would you consider yourself to be anxious?	_____	_____
Do you think you may be depressed?	_____	_____
Have you ever received treatment for anxiety or depression?	_____	_____
If yes, details _____		
Do you have pain which interferes with sleep?	_____	_____
What time do you usually eat dinner? _____		
Do you exercise regularly?	_____	_____
If yes, what time of day? _____		
Do you drink caffeine in any form (Tea, coffee, soda, cocoa, sport drinks)?	_____	_____
If yes, number per day _____		
Do you frequently eat chocolate?	_____	_____
Are you taking or have you taken any sleeping medication that seems to help?	_____	_____
Details _____		

Signature: _____

Date: _____