Sierra Pulmonary & Sleep Institute

"Comprehensive Compassionate Care"

SLEEP QUESTIONNAIRE

Please complete and bring to your sleep study appointment.

Name: _____Date of Birth: _____

Current Weight: _____lbs. Max. Weight: _____lbs. Height: ____ft. ____in

Please circle the correct answer or write requested information in the space provided.

1. Describe the sleep or wake problem(s) that concerns you.

_____
_____
_____
_____

2. How long have you had this problem? _____
3. Have you had a sleep evaluation or study before this? Yes / No

   If yes, when and where? _____
4. What is your occupation? _____
5. Are your working hours variable? Yes / No
6. Describe what type of bed you sleep on (mattress, water bed, etc.):

   _____
7. Do you sleep with a bed partner? Yes / No
8. How long does it take you to fall asleep at night? _____min. _____hrs.
9. What time do you usually go to bed?

   Weekdays: _____am/pm Weekends: _____am/pm
10. What time do you usually get up in the mornings?

    Weekdays: _____am/pm Weekends: _____am/pm
11. Do you awaken during your nights sleep? Never / Occasionally / Often
12. What is the total amount of time that you are **awake** during the night? _____min. _____hrs.
13. What is the total number of hours of **sleep** that you usually get a night? (Please DO NOT include time that you spend awake in bed during the night.) _____min. _____hrs.
14. Are you restless during sleep? Never / Occasionally / Often
15. Do you smoke or have you Smoked? Yes / No

    If yes, how long have you or did you smoke? _____

How many packs per day? _____

When did you quit? _____

16. Do you drink alcohol? Yes / No

    If yes, how much per week? _____

17. Do you use recreation drugs? Yes / No

    If yes, which ones? _____

18. Do you use caffeinated beverages? (coffee, soda, etc.) Yes / No

    If yes, at what time do you drink your last cup of the day? _____am/pm

19. Do you snore? Yes / No / Occasionally

20. Have you been told you stop breathing in your sleep? Never / Occasionally / Often

21. Do you ever feel short of breath during sleep? Never / Occasionally / Often

22. Do you sometimes have a headache when you awaken? Never / Occasionally / Often

23. Do you have a problem with FATIGUE (tiredness, exhaustion, lethargy) even when you are NOT sleepy? Never / Occasionally / Often

24. Are you sleepy (drowsy) during the day? Never / Occasionally / Often

25. **Regarding drowsiness, rather than just fatigue, enter the number that corresponds to how likely drowsiness is to occur to you in the following situations:**

    0 = NEVER OCCURS

    1 = OCCASIONALLY OCCURS (less than 50% of the time)

    2 = OFTEN OCCURS (50% of the time)

    3 = USUALLY OCCURS (more than 50% of the time)

    Sitting and reading: _____

    Watching TV: _____

    At a public place, like a theater or meeting: _____

    While a passenger in a car, riding for one hour or more: _____

    Lying down in the afternoon: _____

    Sitting and talking to someone: _____

    Sitting down after lunch: _____

    While driving a care and stopped at a traffic light: _____

    TOTAL: _____

26. Do you experience vivid, dream-like scenes even though you think you are awake? Never / Occasionally / Often

27. Do you have weak knees or episodes or muscular weakness when laughing, angry, or in emotional situations? Never / Occasionally / Often

28. Do you have persistent, repeating or violent dreams? Never / Occasionally / Often
29. Have you ever acted out your dreams or woke up doing so? Never / Occasionally / Often
30. Do you awaken from sleep screaming, violent and confused? Never / Occasionally / Often
31. Have you been told that you grind your teeth in sleep? Never / Occasionally / Often
32. Do you have a sour or acid taste, in your mouth during sleep? Never / Occasionally / Often
33. Do you have heartburn or chest pain during sleep? Never / Occasionally / Often
34. Do you gag, choke, or cough during sleep? Never / Occasionally / Often
35. Do you, or have you been told you, frequently kick your legs during sleep?
    Never / Occasionally / Often
36. Do you have a feeling that you need to move your legs when trying to sleep?
    Never / Occasionally / Often
37. Is your sleep disturbed, during the night, because of:
    - Having thought racing through your mind? Never / Occasionally / Often
    - Feeling sad and depressed? Never / Occasionally / Often
    - Anxiety (worry about things)? Never / Occasionally / Often
    - ***Do you have a fear of not being able to sleep once you have awakened during the night? Never / Occasionally / Often***
38. Have you ever had seizures or epilepsy? Never / Occasionally / Often
39. Do you experience any pain or discomfort during sleep? Never / Occasionally / Often
40. Do you feel that you have a sexual concern? Never / Occasionally / Often
41. How MUCH stress do you have at the present time? Not Much / Some / A lot
42. Are you claustrophobic? Yes / No
43. Do you have to get up to go to the bathroom during your sleep period? Yes / No
44. I feel that my sense of well-being or happiness has been reduced by my sleep problems? Yes/No
45. I feel that my productivity at work or home has been reduced by my sleep problems Yes / No
46. I feel that my financial resources have been reduced or affected by my sleep problems: Yes / No

Please use this space to provide any other information you would like us to know:

_____
_____
_____
_____
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