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# SLEEP QUESTIONNAIRE

**FULL NAME: _____ DOB: _____ GENDER: _____**

**WHAT IS YOUR PRIMARY PROBLEM WITH SLEEP? _____**

**_____**

**HOW LONG HAVE YOU HAD THIS PROBLEM? _____**

## SLEEP SCHEDULE/SLEEP HYGIENE

**WHAT TIME DO YOU USUALLY GO TO BED? _____ WEEKEND/HOLIDAY? _____ WEEKDAY/WORKDAY? _____**

**DO YOU TAKE DAYTIME NAPS? _____ ARE YOU REFRESHED AFTER A NIGHT'S SLEEP? _____**

**DO YOU HAVE A FAIRLY REGULAR SLEEP/WAKE CYCLE? _____**

**DO YOU DO ANY OF THE FOLLOWING IN BED? READ / EAT / WATCH TV / WORRY / WRITE**

**DO YOU CURRENTLY DO SHIFT WORK? _____ HAVE YOU DONE IT IN THE PAST? _____**

**DO YOU HAVE TROUBLE SLEEPING WHEN YOU DO SHIFT WORK? _____**

**IF YOU COULD SET YOUR OWN SCHEDULE, WHEN WOULD YOU GO TO BED? _____**

**IF YOU COULD SET YOUR OWN SCHEDULE, WHEN WOULD YOU WAKE UP? _____**

## INSOMNIA

**DO YOU OFTEN HAVE TROUBLE FALLING ASLEEP? _____ AVERAGE MINUTES TO FALL ASLEEP? _____**

**DO YOU HAVE FREQUENT AWAKENINGS? _____ TROUBLE FALLING BACK ASLEEP? _____**

**HOW MANY NIGHTS A WEEK DO YOU HAVE A PROBLEM SLEEPING? _____**

**IS YOUR SLEEP DISRUPTED BY YOUR BED PARTNER? YES / NO IF YES, WHY? _____**

## PARASOMNIAS

**ANY TROUBLE SLEEPING AS A CHILD? _____ DID YOU WET THE BED AS A CHILD? _____**

**DO YOU CURRENTLY HAVE NIGHT TERRORS? _____ DO YOU ACT OUT YOUR DREAMS? _____**

**DO YOU CLENCH OR GRIND YOUR TEETH AT NIGHT? _____**

**HAVE YOU RECENTLY SLEEPWALKED? _____ HAVE YOU EVER BEEN TOLD THAT YOU SLEEPWALK? _____**

## MOVEMENT

**DO YOU HAVE A DISCOMFORT (CRAWLING SENSATION) IN YOUR LEGS DURING WAKING HOURS? _____**

**DO YOU EXERCISE REGULARLY? _____**

**EXCESSIVE SLEEPINESS**

**DO YOU FEEL EXCESSIVE SLEEPINESS DURING THE DAY? _____**

**HAVE YOU EVER HAD AN ACCIDENT OR "NEAR MISS" DUE TO FALLING ASLEEP DRIVING? _____**

**HAVE YOU EVER FELT SUDDEN MUSCLE WEAKNESS WHEN LAUGHING, ANGRY, OR SURPRISED? _____**

**HAVE YOU EVER BEEN UNABLE TO MOVE YOUR BODY WHILE FALLING ASLEEP/WAKING-UP? _____**

**DO YOU HAVE TROUBLE DISTINGUISHING DREAMS FROM REALITY? _____**

**DO YOU HAVE MORNING HEADACHES? NEVER / MONTHLY / WEEKLY / DAILY**

**DO YOU WAKE WITH A DRY MOUTH OR SORE THROAT? NEVER / MONTHLY / WEEKLY / DAILY**

**HAVE YOU BEEN TOLD YOU STOP BREATHING WHILE ASLEEP? NEVER / MONTHLY / WEEKLY / DAILY**

**DO YOU WAKE SNORTING, CHOKING, OR SHORT OF BREATH? NEVER / MONTHLY / WEEKLY / DAILY**

**HOW OFTEN DO YOU SNORE? NEVER / MONTHLY / WEEKLY / DAILY**

**IF YES, HOW LOUD HAVE YOU BEEN TOLD YOUR SNORING IS? N/A / SLIGHT / MODERATE / LOUD**

**WHICH POSITIONS DO YOU PREFER TO SLEEP IN? BACK / LEFT SIDE / RIGHT SIDE / STOMACH / OTHER: _____**

**DOES YOUR POSITION AFFECT YOUR SNORING? N/A / YES / NO / NOT SURE**

**DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE? YES / NO**

**DO YOU HAVE A HISTORY OF UPPER AIRWAY SURGERY(S)? _____**

**DO YOU HAVE GASTRIC REFLUX, HEARTBURN, OR A HIATAL HERNIA? _____**

**DO YOU USE OXYGEN OR ANY TYPE OF MEDICAL EQUIPMENT WHEN SLEEPING? _____**

**HAVE YOU GAINED WEIGHT? _____ HAVE YOU ATTEMPTED DIETING? _____**