

SLEEP DISORDERS QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____
Last
First
Middle

- 1) What is your height _____
- 2) What is your weight? _____
- 3) Have you had any previous evaluations, examination, or treatment for this sleep problems or any other problem with your sleep? Yes _____ No _____
- 4) Have you used any medication (prescribed or otherwise) to help your sleep problem? Yes _____ No _____
 If yes, list below:

Medication	Dosage	How Often	Reason Used	How Long	Usefulness	Prescribing MD

- 5) On the average, how long does it take you to fall asleep at night after you turn out your bedroom lights? _____
- 6) How difficult is it for you to awaken and get out of bed after sleeping?
 Very Difficult _____ Difficult _____ Sometimes Difficult _____ No Problem _____
- 7) Do you nap or return to bed after arising? Yes _____ No _____
 If yes, how many times per day? _____ Average length of nap: _____ Hrs. _____ Min.
- 8) Are you bothered by sleepiness during the day? Yes _____ No _____
- 9) Do you experience drowsiness (a tendency to fall asleep) while driving? Yes _____ No _____
 If yes, is this with short _____ or long _____ distance driving?
- 10) Has anyone noticed that you have apnea (stop breathing) while you sleep? Yes _____ No _____
- 11) Have you ever (a) suddenly fallen? Yes _____ No _____
 (b) experienced sudden bodily weakness? Yes _____ No _____
- 12) If yes, were you aware of your surroundings? Yes _____ No _____
- 13) Have you ever experienced weakness or paralysis when:
 (a) Going to sleep? Yes _____ No _____
 (b) Awakening from sleep? Yes _____ No _____
- 14) Do you have difficulty breathing through your nose? Yes _____ No _____
 If yes, I have trouble: All day _____ At night _____ Both day and night _____.
- 15) Have you ever had: (a) Tonsillectomy..... Yes _____ No _____ When _____
 (b) Adenoidectomy..... Yes _____ No _____ When _____
 (c) Nasal or sinus surgery..... Yes _____ No _____ When _____
 (d) Vocal cord surgery (polyp, nodules, etc.)..... Yes _____ No _____ When _____
 (e) Other head and neck surgery Yes _____ No _____ When _____