

PATIENT SLEEP QUESTIONNAIRE

Dear Patient:

Please complete this questionnaire accurately and mail it to Neurology & Sleep Medicine, 2402 W. Pierce St., Suite 5C, Carlsbad, NM 88220 or fax it to (505) 887-5511 prior to your sleep study. This questionnaire will help us with your sleep study. Thank you for your cooperation.

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1. What is your usual bedtime? _____ how many hours per day?
 2. What time do you get up in the morning?
 3. Do you wake up in the middle of the night? No Yes, how many times?
 4. How long does it take you to fall asleep?
 5. How many hours of sleep do you get each night?
 6. Do you feel rested in the morning?
 7. Do you feel tired during the day?
 8. Do you take naps during the day?
 9. Do you smoke? No Yes, how many cigarettes per day and for how long?
 10. Do you drink caffeinated beverages? No Yes, how many cups per day?
 11. Do you have any alcoholic beverages during the day? No Yes, how many glasses?
 12. Do you or have you ever done shift work? No yes, when was the last time?
 13. If you do shift work, do you have difficulty switching from night to day sleep and vice versa?
 14. How many times a week do you sleep away from home?
 15. Do you take sleeping pills? No Yes, for how long?
 16. Do you take oxygen at night? No Yes, how many liters per minute, and
 17. Do you sleep alone or with someone?
 18. Do you go to sleep with the TV on?
 19. What is your usual sleep position?
 20. Do you take any medications? No yes, please list them on the back of this sheet.
 21. Do you take any medications to help you fall asleep? No yes, please list them on the back of this sheet.
 22. Do you do any of the following during sleep?
 Snore Loud Moderate Light
 Wake up gasping for air Grind your teeth
 Talk Walk
 Have twitching legs or feet
 Have difficulty going to sleep
 Have difficulty staying asleep
 23. How long have you known of the behavior(s) that you checked above? _____ years?
 24. What is your main sleep complaint?
 Trouble falling asleep
 Trouble staying asleep Snoring
 Being sleepy or tired during the day
 Unwanted behaviors during sleep. Please explain on the back:
 Other (Explain on the back):
 25. Do you have any special considerations we should be aware of? No Yes, please list them on the back of this sheet.