

Patient Sleep Questionnaire

Dear Patient:

Please complete this questionnaire accurately and bring it with you the night of your study. This questionnaire will give us a better understanding of your sleep related problems and will help us with your sleep study. Thank you for your cooperation.

Name

Height

Weight

D.O.B.

1. What is your usual bedtime?
2. What time do you get up in the morning?
3. Do you wake up in the middle of the night?
If so, how many times?
4. How long does it take for 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?
If so, how many cigarettes per day and for how long ?
10. Do you drink caffeinated beverages?
If so, how many cups per day?
11. Do you have any alcoholic beverages during the day? If so, how many glasses?
12. Do you or have you ever done shift work?
If so, 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? If yes, for how long?
16. Do you take oxygen at night? If yes, how many liters/minute and how many hours per day?

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? If so, please list them on the back of this sheet.
21. Do you take any medications to help you fall asleep? If so, 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 or 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 or has there been any alarming situations caused due to you being tired? (ex. Fell asleep driving.) If so, please list them on the back of this sheet.