SLEEP DISORDERS SURVEY
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North Collier Sleep Diagnostic Center

IDENTIFYING INFORMATION

Patient's Name_____ Age _____
Last, First Middle

Height _____Weight_____ Lbs.

D.O.B. / / Sex M F Marital Status (circle) S M D

Neck Size_____ inches

Your Address_____

Telephone_____

Your occupation:_____

Your primary care physician:_____

Specialist who referred you to the Sleep Disorders Institute (if applicable):

_____

Place and date(s) of prior evaluation(s) for sleep disorders (if any):

Clinic or Hospital_____

Date _____

Instructions:

Your responses to this questionnaire will offer your sleep lab a comprehensive overview of your sleep. Please answer all questions to the best of your ability.
Expect that the questionnaire will take you 15 to 20 minutes to complete.

SLEEP ENVIRONMENT

Is there any aspect of your sleep environment that contributes to your sleep problem? Yes ❑ No ❑

Are you bothered by the lighting conditions of your bedroom during sleep? Yes ❑ No ❑

Is your bedroom too hot or too cold during sleep? Yes ❑ No ❑

Is your bedroom too humid or too dry? Yes ❑ No ❑

Are you bothered by noise during sleep? Yes ❑ No ❑

Is your bed or bedding uncomfortable? Yes ❑ No ❑

Do you sleep with anyone else in the same room or the same bed? Yes ❑ No ❑

If yes, are you bothered by your roommate's or bed partner's snoring or movements during sleep? Yes ❑ No ❑

If yes, do you sleep in the same room or same bed with your children? Yes ❑ No ❑

Do you sleep in the same bed with a pet? Yes ❑ No ❑

SLEEP HABITS

What is your usual bedtime (the time your get into bed)? _____ AM / PM

What is your usual rise time (the time you get out of bed)? _____ AM / PM

Do you change your bedtime and rise time on the weekends or on days that you do not work?

_____ AM / PM

Does your bedtime and rise time fluctuate from day to day? Yes ❑ No ❑

If yes, what is your usual bedtime on weekends or non-work days?_____ AM / PM

If yes, what is your usual rise time on weekends or non-work days?_____ AM / PM

How long does it usually take you to fall asleep after you get into bed?_____ mins

How many times do you usually awaken during the sleep period?_____ times

What is the average duration of your awakenings?_____ mins

On average, how long would you say you actually are asleep each night? _____hrs

Do you have a regular, nightly routine that you follow every night before getting into bed? Yes ❑ No ❑

If yes, what do you usually do?_____

DAYTIME FUNCTIONING

Do you usually feel sluggish, sleepy, or fatigued upon awakening in the morning? Yes ❑ No ❑

Do you usually feel fatigued throughout the day? Yes ❑ No ❑

Are you bothered by low mood, irritability, or anxiety during the day? Yes ❑ No ❑

Are you bothered by problems with attention, concentration, or memory during the day? Yes ❑ No ❑

Do you find it hard to persist at things you are doing, even simple things? Yes ❑ No ❑

Do you have difficulty functioning in social situations due to fatigue? Yes ❑ No ❑

Do you have difficulty functioning at work due to fatigue? Yes ❑ No ❑

Are you usually bothered by sleepiness during the day? Yes ❑ No ❑

Do you feel that you've lost motivation to do things, or that you've lost interest or pleasure in activities that you used to enjoy? Yes ❑ No ❑

Has your sex drive (libido) diminished? Yes ❑ No ❑

Have you been eating less than usual, or have you recently lost weight? Yes ❑ No ❑

Have you been eating more than usual, or have you recently gained weight? Yes ❑ No ❑

Do you tend to fall asleep in sedentary situations (for example, while watching television, working at a computer, in meetings)? Yes ❑ No ❑

Do you fall asleep when in a warm room? Yes ❑ No ❑

Do you tend to fall asleep at inappropriate times? Yes ❑ No ❑

Has your sleepiness or falling asleep ever put you or someone else in danger? Yes ❑ No ❑

Have you had a motor vehicle accident due to sleepiness or fatigue? Yes ❑ No ❑

Do you feel disabled by daytime sleepiness or fatigue? Yes ❑ No ❑

Do you usually nap during the day? Yes ❑ No ❑

If Yes: How long do you usually nap? _____ minutes

What time of day do you usually nap? Morning / Afternoon / Evening

How many naps do you usually take per day? _____

How many naps do you usually take per week? _____

Do you read, watch television, or engage in other activities while in bed before sleep onset? Yes ❑ No ❑

Do you usually eat before getting into bed, or while in bed before sleep onset? Yes ❑ No ❑

Do you tend to "watch the clock" before or during your sleep period? Yes ❑ No ❑

SNORING AND DIFFICULTY BREATHING DURING SLEEP

Do you snore? Yes ❑ No ❑
Have you been told that you snore loudly, or that your snoring disturbs others? Yes ❑ No ❑
Have you awakened yourself or someone else with your snoring sounds? Yes ❑ No ❑
Is snoring a source of distress in your marriage or other significant relationship? Yes ❑ No ❑

Has anyone ever told you that you seem to have difficulty breathing or that you stop breathing during sleep? Yes ❑ No ❑
Do you ever awaken with the sensation of shortness of breath? Yes ❑ No ❑
Do you ever awaken gasping, choking, or "gulping for air?" Yes ❑ No ❑
Do you often awaken with a dry mouth or sore throat? Yes ❑ No ❑
Do you ever awaken feeling disoriented or confused? Yes ❑ No ❑
Do you ever awaken with headaches? Yes ❑ No ❑
Do you use the restroom frequently at night? Yes ❑ No ❑
Do you experience "acid reflux," "acid indigestion," ? Yes ❑ No ❑
(Men) Do you have difficulty getting or keeping an erection? Yes ❑ No ❑
Have you had surgery for snoring or sleep apnea? Yes ❑ No ❑
Have you been treated for snoring or sleep apnea with a dental device? Yes ❑ No ❑
Have you been treated for snoring or sleep apnea with nasal CPAP, BiPAP, or Autopap? Yes ❑ No ❑

DIFFICULTY FALLING ASLEEP AND STAYING ASLEEP

Do you usually have difficulty falling asleep at the beginning of the sleep period? Yes ❑ No ❑
Are you bothered by awakenings that occur during the night (after you've fallen asleep)? Yes ❑ No ❑
Do you wake up too early and find that you can't return to sleep? Yes ❑ No ❑
Does difficulty falling asleep or staying asleep interfere with your daytime functioning? Yes ❑ No ❑
Do you start dreaming right after you fall asleep? Yes ❑ No ❑
Upon falling asleep or waking up have you ever felt like you were unable to Move your arms or legs, even if you try? Yes ❑ No ❑
Have you ever had a seizure? Yes ❑ No ❑

NARCOLEPSY

Have you ever experienced “sleep attacks” (sudden, irresistible urge to sleep)? Yes ❑ No ❑
Upon falling asleep or waking up have you ever had the experience of seeing things or hearing things that were not really there? Yes ❑ No ❑
Do your leg movements disturb your bed partner? Yes ❑ No ❑
Do you notice that your hands and feet are cold prior to, during, or after sleep? Yes ❑ No ❑
Do you experience painful or unusual sensation of your legs that awaken you? Yes ❑ No ❑
If you answered yes to any of the above items, does walking or massage seem to relieve the discomfort in your legs? Yes ❑ No ❑
Do you ever experience “twitching” or “jerking” of your feet or legs while asleep? Yes ❑ No ❑

SLEEP AND SLEEP-RELATED MOVEMENTS

Do you experience painful or unusual sensations of your legs while at rest, especially in the evening? Yes ❑ No ❑
Do painful or unusual sensations of your legs interfere with your ability to fall asleep? Yes ❑ No ❑

SLEEP RHYTHMS

Do you suffer from jet lag? Yes ❑ No ❑
Are you a shift worker (evenings, nights, or rotating shifts)? Yes ❑ No ❑

If employed, what are your usual work hours? Start shift:_____ AM / PM End: _____ AM / PM

PARASOMNIAS

Please indicate if you have experienced the following symptoms at any time.

Problem Behavior Check “yes” if past or current problem
Sleepwalking Yes ❑ No ❑
Sleepwalking associated Yes ❑ No ❑
with “night eating” Yes ❑ No ❑
Sleepwalking associated with injury to self/others Yes ❑ No ❑
Nightmares Yes ❑ No ❑
Night Terrors Yes ❑ No ❑
Bed Wetting Yes ❑ No ❑
Difficulty swallowing during sleep Yes ❑ No ❑
Sleep talking Yes ❑ No ❑

MEDICAL STATUS AND HISTORY

Have you now, or have you ever in the past, received treatment for high blood pressure? Yes ❑ No ❑

Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? Yes ❑ No ❑

Have you ever suffered a stroke? Yes ❑ No ❑

Have you ever suffered a heart attack? Yes ❑ No ❑

Have you been told that you have GERD,(reflux disease), acid indigestion, or dyspepsia? Yes ❑ No ❑

Have you ever been hospitalized for any reason? Yes ❑ No ❑

If yes, why?

Have you ever had surgery? Yes ❑ No ❑

If yes, why?

Have you ever had a serious injury? Yes ❑ No ❑

If yes, why?

CURRENT MEDICATIONS

Please list all **prescription** and **over-the-counter** medications that you currently use. Include the dose and number of times per day.

_____
_____
_____
_____
_____
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FOOD AND BEVERAGES

Do you usually drink caffeinated beverages (coffee, tea, cola) within 6 hours before bedtime? Yes ❑ No ❑

Do you drink caffeinated beverages during the day to help you stay awake? Yes ❑ No ❑

On average, do you consume more than 5 alcoholic drinks per day? Yes ❑ No ❑

On average, do you consume more than 15 alcoholic drinks per week? Yes ❑ No ❑

Do you drink alcohol (beer, wine, or hard liquor) shortly before bedtime? Yes ❑ No ❑

Do you use alcohol to help you fall asleep? Yes ❑ No ❑

Do you smoke cigarettes? Yes ❑ No ❑

Do you smoke cigars or a pipe? Yes ❑ No ❑

Do you smoke just before bed, or if you happen to awaken during your sleep period? Yes ❑ No ❑

FAMILY AND SOCIAL HISTORY

Number of siblings: _____ Ages of your children: _____
Mother's age: _____ If deceased, what was the year and cause of death?
_____
Father's age: _____ If deceased, what was the year and cause of death?_____

Does anyone in your family have any sleep problems? Yes ❑ No ❑
If so, briefly describe and give their relationship to you:

Does anyone in your family have a history of serious medical or psychiatric problems? Yes ❑ No ❑
If so, what is their problem and what is their relationship to you?

Is there any additional information regarding your sleep, medical, or family histories that you would like to add?

Please return all completed questionnaires to:

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