

SLEEP CENTER OF CENTRAL ILLINOIS LLC

Sleep Questionnaire

Name: _____ Telephone: (Home) _____

Address: _____ Telephone: (Work / Alt.) _____

City: _____ State: _____ Zip: _____

Family Physician: _____

City: _____ State: _____ Zip: _____

My main sleep complaint is:

- I have trouble sleeping at night
- I am sleepy all day
- I have unwanted behaviors when I am asleep

Explain:

Current medical conditions for which I am being treated are:

Medications I am currently taking:

Allergies to medications: _____

SLEEP HABITS

On weekdays, (work days) I usually go to bed at: _____

On weekdays (work days) I wake up at: _____

I take a nap about _____ days each week.

The amount of time that I usually take to fall asleep is: _____

The number of times that I usually wake up during the night is: _____

If I wake up during the nights, the time it usually takes me to fall asleep again is: _____

My total sleep time per night is: _____

Place a check beside any of the following statements that are true for you:

- I have a job that involves shift work or night work
- I frequently travel across time zones (east – west travel)
- I feel that sleep is a waste of time
- I enjoy sleeping very much
- I usually sleep with a bed partner

- I sleep with earplugs or eye shades

During the first 30 minutes after waking up in the morning, I usually feel:

- Very groggy
- Somewhat drowsy
- Slightly drowsy but awake
- Alert

DAYTIME SLEEPINESS

Place a check beside any of the following statements that are true for you:

- I have sometimes fallen asleep at very inappropriate times, such as driving, eating, or during a conversation.
- I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.
- I am frequently so sleepy during the day that my work is poor.
- I have had accidents or near accidents when driving because I felt so sleepy.
- I frequently do not feel sleepy at bedtime and stay up until it is so late that as a consequence I get too little sleep.
- I would feel better if I slept at least one more hour every night.
- I feel that I sleep too much.
- I feel that I sleep too little.
- I function best in the morning.
- I function best in the evening.
- I've "come to" or suddenly become alert and found myself doing things without being aware of having started them, or how I got there.
- All day I generally feel: Tired Sleepy
- When I get a good night of sleep, I feel better the next day.
- Several times recently I got up later than planned, even though I went to bed at the right time.
- Usually I find myself falling asleep during half-hour TV shows.
- Sometimes I perform a complex act such as driving a car to the wrong destination and not remember how I did it.
- I sometimes find myself doing things which make no sense (such as writing nonsense or mixing chocolate and gravy)
- I've had the sensation of sudden weakness in my legs while awake (this may occur particularly in emotional situations, such as laughter, anger etc.).
- I sometimes have felt paralyzed or unable to move when waking up or falling asleep.
- I have hallucinations or dreamlike images when I am not actually asleep but while falling asleep or waking up.

PARASOMNIAS

Place a check beside any of the following statements that are true for you:

- I feel as if I have to move my legs
- I have been told that I grind my teeth when I sleep.
- As an adolescent or adult, I have been seen sleep walking.
- As an adolescent or adult, I have been sleep talking.
- My dreams are often very vivid.
- I feel that I dream too much.
- My dreams often awaken me.
- I often have frightening dreams.
- As an adult I have wet my bed.
- I've been told that I bang or twist my head at night.

DISTURBED SLEEP

Place a check beside any of the following statements that are true of you:

- I have been told that I snore very loudly.
- Sometimes a person cannot sleep in the same room with me because he / she is bothered by my snoring.
- My bed covers are very messed up in the mornings.
- I am a very restless sleeper.
- I have been told that I kick or poke my bed partner while I am asleep.
- I sometimes awaken with a choking sensation.
- I've been told that I stop breathing when I sleep.
- I have fallen out of bed.
- I have been told that I make rolling or rocking movements during my sleep.
- I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension, or unhappiness.
- I have awakened from sleep once or more having vomited.
- When I wake during the night, I often have to get up and go to the bathroom.
- I sweat a lot when I sleep.
- I feel that the quality of my sleep is unsatisfactory.
- I have been told that my legs twitch or jerk while I am sleeping.
- I sometimes wake up with a headache.
- I sometimes have pain from my heart during the night.
- I usually have a bitter or sour taste in my mouth when I awaken at night or in the morning.

INSOMNIA

Place a check beside the following statements that are true for you:

- I have trouble falling asleep at night
- When I don't sleep well, I worry about it the next day.
- When I wake up during the night, I have trouble going back to sleep.
- I wake up in the morning long before I have to.
- Some nights, I never get to sleep no matter how hard I try.
- When I try to go to sleep, my mind races with many thoughts.
- At night when I go to bed I don't feel sleepy.
- I often sleep better in an unfamiliar bedroom, such as a hotel or motel room.
- When I try to fall asleep I become anxious or nervous.
- When I try to fall asleep I worry about whether or not I can sleep.
- When I try to fall asleep I often feel hungry or thirsty.
- When I try to fall asleep I feel Pain.
- Pain often wakes me up or keeps me from going back to sleep.
- I often take sleeping pills in order to sleep.
- I have a creeping, crawling sensation in my legs when I lie down to sleep.
- When I do sleep, I feel that I sleep very well.
- I am a very light sleeper; I am easily awakened by noises.
- My sleep is disturbed because of my bed partner.
- Heat or cold disturbs my sleep.
- Generally I get up in the middle of the night for a snack.

MEDICAL CONDITIONS

Place a check beside any of the following statements that are true for you:

- I have been told that I shake my head at night.
- I have been told that I have convulsions, fits, or seizures at night.
- I have had convulsions, fits, or seizures during the day.
- I have bitten my tongue while asleep.
- I sometimes wake up with heartburn.
- I sometimes wakeup with lower back pain.
- I sometimes wake up with feelings of aching or "pins and needles" in my legs.

- I am unable to sleep in a flat position because of shortness of breath.
- I sometimes cough up sputum or mucus during the night or in the morning.
- I have gained more than 10 pounds in the last year.
- I have lost more than 10 pounds in the last year.
- I have been told that I have high blood pressure.
- I rarely drink alcoholic beverages.

I consume the following:

	Weekdays	Weekend Days
Bottles / cans of beer	_____	_____
Glasses of wine	_____	_____
Shots of liquor	_____	_____

- I use alcohol in order to get to sleep: Sometimes Often

MEN

- I awaken with painful penile erections.
- I have problems obtaining or maintaining penile erections.

WOMEN

- My sleep problem varies according to the stage of my menstrual cycle.
- I am currently taking birth control pills.
- My sleep problem started and got worse at menopause.

SLEEP HISTORY

Place a check beside any of the following statements that are true for you. (If possible, please ask your parents or older brothers or sisters to help you remember your childhood behavior.)

- I sometimes wet the bed after the age of 6.
- As a child I talked in my sleep.
- As a child I sleep walked.
- As a child I had frequent nightmares.
- As a child I screamed in my sleep.
- As a child I had convulsions during sleep.
- As a child I banged or rocked my head on the bed to sleep.
- My current sleep problem started in childhood.
- .
- I used to fall asleep in school as a child or adolescent.
- I always had to fight the urge to sleep during my classes at school when I was a child or adolescent.
- As a child I used to stay up late in the evening.

- I was told that I snored while sleeping as a child or teenager.
- I was considered a hyperactive or hyperkinetic child or teenager.

FAMILY HISTORY

These questions apply to your extended family: parents, children, aunts, uncles, cousins, nieces, nephews, etc. – relatives related by blood.

- A relative died from crib death or sudden infant death.
- Other members of my family have insomnia.
- Others members of my family snore loudly at night.
- Other members of my family frequently fall asleep during the day or evening.
- Other members of my family are troubled by sudden attacks of physical weakness or paralysis, particularly in emotional situations.
- Other members of my family have been hyperactive or hyperkinetic as children.
- Other members of my family have the same sleep problem that I do.

ALLERGIES

- None
- Medications: Describe reaction
- Other

HABITS

- Sleep aids
- Marijuana
- Other substance (s)
- Cigarettes: Packs (s) per day for _____ years.
 Former smoker _____ pack(s) per day for _____ years.