

Rappahannock Neurology Specialists
Confidential Patient Sleep Questionnaire

Name: _____ **Age:** _____ **Date:** _____

-What is the primary concern regarding your sleep?

- | | |
|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Pauses in your breathing/witnessed apneas |
| <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Unusual behaviors in sleep (acting out dreams, walking, kicking, eating) |

Others: _____

- Describe how you feel when you wake up in the morning:

- | | | | |
|------------------------------------|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Tired | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Drowsy | <input type="checkbox"/> Sleepy |
| <input type="checkbox"/> Groggy | <input type="checkbox"/> Irritable | <input type="checkbox"/> Depressed | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Refreshed | <input type="checkbox"/> Ready to go | <input type="checkbox"/> Trouble concentrating |

- Do your sleep problems interfere with your daily activities such as work/home? Y/N

- How long have you had the above problems? _____ months/years

-Have you had a formal evaluation for sleep problems in the past? Y/N

-Have you had a sleep study in the past? Y/N

-If yes, give details if you can (Name of doctor, diagnosis and treatment)

Other Sleep Complaints

- | | | |
|---|---|--|
| <input type="checkbox"/> Snoring worse on back | <input type="checkbox"/> Gaspings, choking sounds | |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Septoplasty (nose surgery) | |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Grind teeth (if yes, mouth guard? Y/N) | |
| <input type="checkbox"/> Heartburn at night | <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Scream | <input type="checkbox"/> Act out dreams | <input type="checkbox"/> Eat while sleep |
| <input type="checkbox"/> See or hear things/dreaming upon falling asleep/ waking | | |
| <input type="checkbox"/> Feel paralyzed or weak in your muscle when excited/angry (ex knees buckle) | | |

If yes, elaborate _____

Routine Sleep Habits

- Are you a shift worker? Y/N if yes, working hours are: _____
- On weekdays, what is your bedtime _____ am/pm Get up _____ am/pm
- On weekends, what is your bedtime _____ am/pm Get up _____ am/pm
- What is your ideal bed/wake times _____ am/pm Get up _____ am/pm
- How long does it take you to fall asleep? _____ minutes/hours
- Do you have difficulty initiating sleep (insomnia)? Y/N _____ # nights/week
- What keeps you from going to sleep? Racing thoughts Stress/worry
 Pain Jumpy legs Noise Others _____
- Do you have any of these signs in evening or as you are preparing for sleep?
 Agitation/ tension Hyper vigilant Racing mind
- If you take sleeping pills to help you sleep, name them _____
- Do you worry a lot about your sleep and why? Y/N _____
- Do you sleep better at: Your home Weekends (vs. working days) Vacation
- Describe your sleep quality: Restful Restless Toss and turn
- Do you wake up often at night? Y/N _____ # times/night
- What wakes you up from sleep in the middle of the night? _____
- Any trouble going back to sleep? Y/N Reason, _____
- Days per week do you nap? _____ None. Are naps refreshing? Y/N
- If you have a long commute (Wash DC), # hours do you sit in traffic? _____
- What time do you start/finish work _____ am/pm to _____ am/pm
- What is your occupation? _____

For the following situation, indicate your chance of dozing or falling asleep

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up)	_____

Restless Legs Symptoms

- Do you have an urge to move your legs when you are sitting or lying? Y/N
- If yes, are they worse during evening/ night Y/N
- Are they relieved by movement (stretching, getting up) Y/N
- Does a bed partner report kicking/sheets in disarray Y/N

See back side....

General Habits

Do you consume any caffeinated beverages or food? Note if they are decaffeinated

Coffee _____/day

Soda _____/day

Ice tea _____/day

Hot Tea _____/day

Green tea _____/day

Hot chocolate _____/day

Chocolate candy _____/day

Alcohol (Beer, wine, hard liquor) _____/day

Tobacco products _____ if yes, time of last cigarette for the day? _____

-Your current weight:

Height:

-Has your weight changed recently?

Y/N lb ____ Loss/Gain

-Are you on a diet?

Y/N

-Do you exercise

Y/N

-If you exercise, what do you do and how much?

Evening and Nighttime Habits

-What do you usually do in the evening leading to bedtime?

-Dinner time _____ pm

-Do you watch TV in bed?

Y/N

-Do you read in bed?

Y/N

-Do you use the computer at night

Y/N

-Does your bed partner snore?

Y/N

-Do your pets sleep in the bedroom with you?

Y/N

-What time of the day do you take your shower?

Your Signature _____