SLEEP QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth:_____

Current Weight: _____ pounds **Your Heaviest Weight: _____ pounds**

Height:_____ inches Neck Size: _____ inches

Place an "X" or Circle the correct answer or write in the requested information.
Please complete with your bedpartner's help if possible.

Describe the sleep or wake problem that concerns you?

_____

How long have you had this problem?

_____

Have you ever been told you sleep walk? **Never** **Sometimes** **Often**

Do you fall asleep unintentionally? **Never** **Sometimes** **Often**

How long does it take you to fall asleep at night? _____ **Minutes** _____ **Hours**

Do you awaken during the night? **Never** **Sometimes** **Often**
a) How long does it take to get back to sleep? _____ **Minutes** _____ **Hours**
b) Do you know why you awaken?

_____

Do you, or have you been told that you kick your legs during sleep? **Never** **Sometimes** **Often**

Do you experience resltess legs? **Never** **Sometimes** **Often**
(crawling or aching feelings in legs, or inability to keep your legs still)

Do you experience any kind of pain of physical discomfort? **Never** **Sometimes** **Often**

Do you experience vivid dream like episodes when FALLING asleep? **Never** **Sometimes** **Often**

Do you have persistent, repeating or violent dreams? **Never** **Sometimes** **Often**

Have you ever acted out your dreams or woke up doing so? **Never** **Sometimes** **Often**

18.	Have you been told that you grind your teeth in your sleep?	**Never**	**Sometimes**	**Often**
19.	Do you have sour or acid taste in your mouth during sleep or when awakening?	**Never**	**Sometimes**	**Often**
20.	Do you have heartburn or chest pain during sleep?	**Never**	**Sometimes**	**Often**
21.	Do you ever feel short of breath during sleep?	**Never**	**Sometimes**	**Often**
22.	Is your sleep disturbed during the night because of:			
	a) Thoughts racing through your mind?	**Never**	**Sometimes**	**Often**
	b) Feeling sad and depressed?	**Never**	**Sometimes**	**Often**
	c) Anxiety or worries?	**Never**	**Sometimes**	**Often**
	d) Fear of not being able to sleep once you have awakened during the night?	**Never**	**Sometimes**	**Often**
23.	How many hours of sleep do you usuallly get at night during the week? (do not include time spent laying awake in bed)	_____ **hours**	_____ **minutes**	
24.	How many hours of sleep do you usually get at night during the weekend? (do not include time spent laying awake in bed)	_____ **hours**	_____ **minutes**	
25.	How much of a problem do you have feeling tired during the day?	**Never**	**Sometimes**	**Often**
26.	Do you experience weak knees or episodes of muscle weakness when laughing, angy, or during other emotional situations?	**Never**	**Sometimes**	**Often**
27.	Are you claustrophobic?	**Yes**	**No**	
28.	Do you have nasal stuffiness or congestion during sleep?	**Never**	**Sometimes**	**Often**
29.	Have you ever had a sleep evaluation/study before this?	**Yes**	**No**	
	a) If so, when & where _____			

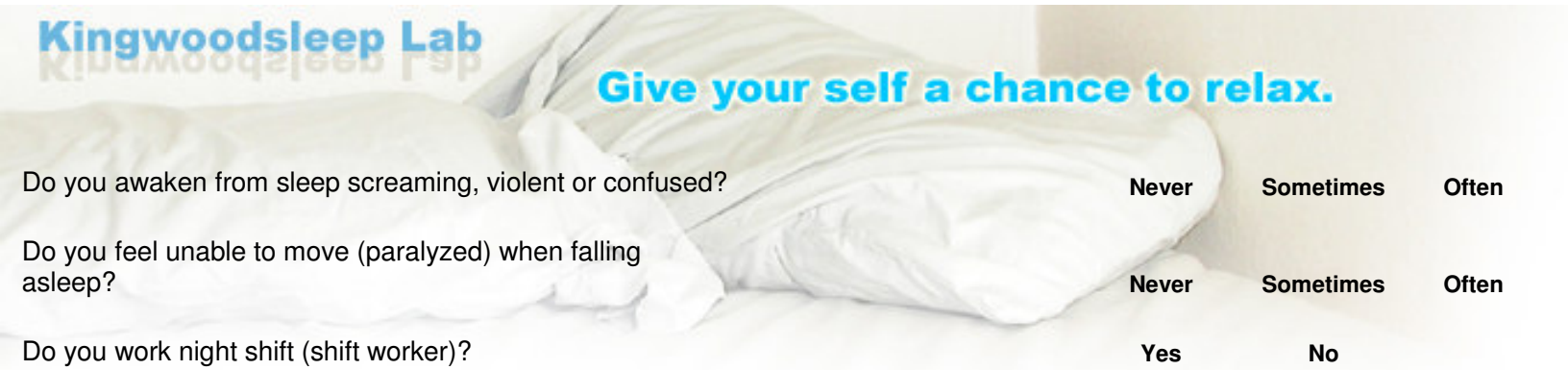
OTHER RELATED HISTORY

30.	Have you ever been treated for a sleep related disorder other than sleep apnea?	**Yes**	**No**
	If so,		
	a) For what?_____		
	b) When & how long?_____		
	c) What drugs did you take? _____		
	d) Who was the doctor?_____		
31.	Have you ever been treated for anxiety or depression?	**Yes**	**No**
	If so,		
	a) For what?_____		
	b) When & how long?_____		

c) What drugs did you take? _____
d) Who was the doctor?_____

32. Have you ever been treated for Sleep Apnea? **Yes** **No**
If so,
a) When_____
b) How long_____
c) Who was the doctor?_____

The information in this document is strictly confidential and may only be used in whole or part as an integral part of the medical/diagnostic/therapeutic report



Do you awaken from sleep screaming, violent or confused?	**Never**	**Sometimes**	**Often**
Do you feel unable to move (paralyzed) when falling asleep?	**Never**	**Sometimes**	**Often**
Do you work night shift (shift worker)?	**Yes**	**No**	
Have you ever had any recent problems remembering or concentrating?	**Never**	**Sometimes**	**Often**
Have you ever had seizures or been diagnosed with Epilepsy?	**Never**	**Sometimes**	**Often**

a) If so, when?_____