Advocate Health Care

Sleep Study Questionnaire

Patient Name: _____ Age: _____

MD ordering Sleep Study: _____

Have you been previously evaluated for a sleep disorder: YES NO If yes, what year, at what institution, and what were the findings: _____

Height: _____ Weight: _____

Medical History (list conditions, high blood pressure, diabetes, asthma, etc.): _____

_____

_____

Medications **including oxygen** (list medications – both prescription and over the counter): _____

_____

_____

Do you have allergies? : YES NO If yes, describe: _____

Do you have a known cardiac arrhythmia? YES NO If yes, what type? _____

Do you suffer from seizure disorder? YES NO If yes, are you being treated? YES NO

If awoken from sleep, do you have any violent tendencies we should know about? YES NO If yes, please describe: _____

Consume _____ alcoholic beverages/day and _____ caffeinated beverages/day

Average tobacco use: _____ cigarettes/day

Marital status: (circle one) married single divorced widowed significant other

Name of children and their ages: _____

Occupation: _____

Does your job involve shift work? YES NO If yes, please describe: _____

(continued on reverse)

Weekdays
Usual bedtime: _____ am/pm Usual awakening time: _____ am/pm

Weekends
Usual bedtime: _____ am/pm Usual awakening time: _____ am/pm

On average how many times do you awaken during the night? _____

If you have a bed partner, have they noticed you doing any of the following during your sleep? (circle)

Stop breathing	Snore	Have gasping arousals	Talking
Jerk your legs	Walking	Grind your teeth	Thrash around

Other: _____

Do you suffer from any of the following? (circle)

Excessive daytime sleepiness	Difficulty initiating sleep	Difficulty maintaining sleep
Frequent nocturnal awakenings	Gasping arousals from your sleep	Leg cramps (charlie horses)
Nasal congestion	Mouth breathing	Heart Burn

Restless legs at sleep onset (discomfort in your limbs that make you need to move around)

Attacks of sudden, brief losses of muscle strength (cataplexy)

Vivid dream-like scenes when drowsy (hypnagogic hallucinations)

Paralysis just prior to falling asleep or upon awakening (sleep paralysis)

Awake from sleep screaming, violent, and confused (night terrors)

How many times have you ever been involved in automobile accidents, or near accidents, because of sleepiness? _____ times

How many daytime naps do you take? _____

Average total time napping during the day _____ minutes/hours

Is there anything else not covered by this questionnaire regarding your sleeping or waking problem that you would like us to know? _____

_____

_____

_____ _____ _____

Date Time Signature