MINNESOTA
SLEEP
INSTITUTE

SLEEP QUESTIONNAIRE

Please fill out this form entirely before your visit.

Name _____ **Sex** _____

Address _____

_____ **Zip** _____

Home phone _____ **Work phone** _____

Occupation _____ **Birth date** _____

Age _____ **Height** _____ **Weight** _____

Referring Physician _____

Address _____

_____ **Zip** _____

We will send a copy of your sleep study to this physician.

How would you like to be addressed by our staff during your visit(s) ?
i.e.. : Bill, Mr. Johnson, Mrs. Green, Ms. Brown, Doctor Smith

_____

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Sleep Chart

Please record your sleep habits for at least two weeks prior to your evaluation. For each night, make a vertical line at the time you went to bed and at the time you got out of bed. Then draw a horizontal line connecting the two. In the two columns at the right, indicate the number of hours in bed, and the number of hours you think you slept.

Name ____________________________________

	Noon						PM						Mid						AM						Hours	Hours
Date	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	**In Bed**	**Asleep**

1.) Reason for Sleep Consultation

Please describe the problem(s) you are having with your sleep:

_____

_____

_____

_____

2.) Duration / History of sleep problem

How long have you had, or have been told about, this problem? _____

Does anyone else in your family have a similar problem? _____

Did this problem start or worsen at the time of any significant stress, physical injury, or weight gain? _____

What have you already tried to reduce your sleep problem? _____

3.) Sleep Schedule

What time do you go to bed on the days that you work? _____

What time do you get up on the days you work? _____

What time do you go to bed on the days you don't work? _____

What time do you get up on the days you don't work? _____

How many hours do you sleep on the days that you work? _____ hours

How many hours do you sleep on the days you don't work? _____ hours

How long does it take you to fall asleep? _____ min

Do you work rotating shifts?_____ If yes, what shifts? _____

Please describe your typical shift rotating pattern. _____

_____

4.) While asleep or in bed

How often do you, or are told that you... *(Please circle response.)*	**Never**	**Sometimes**	**Almost always**
awaken frequently from sleep?	1	2	3
have trouble falling asleep?	1	2	3
have restless or disturbed sleep?	1	2	3
have disturbed sleep due to noise or other things in your environment?	1	2	3
snore loudly?	1	2	3
stop breathing while asleep?	1	2	3
suddenly awaken choking or gasping?	1	2	3
get up to urinate more than once?	1	2	3
have trouble breathing through your nose?	1	2	3
wake up with morning headaches?	1	2	3
wake up with a dry mouth?	1	2	3
awaken from sleep because of coughing, heartburn, or regurgitation?	1	2	3
feel unable to move (paralyzed) when falling asleep or waking up?	1	2	3
have nightmares or screaming in your sleep?	1	2	3
walk or talk in your sleep?	1	2	3
thrash, or have sudden violent body movements while asleep?	1	2	3
grind your teeth while asleep?	1	2	3
notice twitching, kicking, or crawling sensations in your legs while in bed?	1	2	3

5.) During waking hours

How often do you... *(Please circle response)*	**Never**	**Sometimes**	**Almost always**
feel refreshed and alert upon waking?	1	2	3
take naps?	1	2	3
have vivid dreams during naps?	1	2	3
experience sudden muscle weakness or feel as if you might fall down when angry or laughing?	1	2	3
experience dreamlike scenes or hallucinations even though you know you are awake?	1	2	3
need to stop driving because of sleepiness?	1	2	3
have automobile accidents or near misses because of sleepiness?	1	2	3
experience restless, tingling, or crawling sensations in your legs?	1	2	3
feel that you are under unusual pressure or stress?	1	2	3
feel that you are sad or depressed?	1	2	3

6.) Alcohol, Tobacco, Caffeine use

Have you ever smoked cigarettes? ☐yes ☐no Currently ☐yes ☐no

How many years have you smoked? _____ Average number packs per day _____

If you quit smoking: How many years ago? _____ yrs.

Have you ever smoked cigars, a pipe, or chewed tobacco? ☐ yes ☐ no Currently ☐ yes ☐ no

Do you consume alcoholic beverages? ☐ yes ☐ no Drinks per day? _____

Do you use coffee or other caffeinated beverages to stay awake? ☐yes ☐no

Do you use caffeine tablets to stay awake? ☐yes ☐no

7.) Health Problems and Surgeries

Please list all and describe briefly, (include dates of any surgeries).

8.) Medications

Please list all prescription and over the counter drugs used regularly.

Name	Dosage	How Often	Reason

9.) Review of Systems

(please check yes or no for the following conditions)	YES	NO
difficulty breathing through your nose	☐	☐
high blood pressure	☐	☐
wheezing or shortness of breath	☐	☐
difficulty breathing when lying down in bed	☐	☐
frequent urination at night	☐	☐
muscle or joint pains	☐	☐
head injury or loss of consciousness	☐	☐
seizures or epilepsy	☐	☐
stroke	☐	☐
personality change	☐	☐
numbness or tingling in your extremities	☐	☐
anemia	☐	☐
low thyroid	☐	☐
routinely feel colder than others in a room	☐	☐
How many pounds have you gained since high school?	_____ lbs.	

10.) Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

situation	**chance of dozing**
1.) Sitting and reading	_____
2.) Watching Television	_____
3.) Sitting inactive in a public place, e.g.: movie, meeting	_____
4.) As a passenger in a car for an hour without a break	_____
5.) Lying down to rest in the afternoon	_____
6.) Sitting talking to someone	_____
7.) Sitting quietly after a lunch without alcohol	_____
8.) In a car, while stopped for a few minutes in traffic	_____
Please Total your score	_____

11.) Sleep/Wake Problem not covered in the questionnaire

If your Sleep/Wake Problem was not adequately covered by the above questions, briefly describe your symptoms, events, or concerns which would help the physician in your evaluation.

_____

_____

_____

_____

_____

_____

_____

Thank You