

Please answer these questions regarding your sleep habits as completely as possible. Either submit the completed form online or download it and bring it to your scheduled study. You may receive help from your spouse, bed-partner, or roommate if necessary.

Today' Date: _____

Name _____ Date of Birth _____

Height: _____ Weight: _____ Neck Size: _____

Referring Physician _____

Date of Evaluation _____

Main Complaint and Reason for Inquiry: _____

What would you describe your sleep as? (Please check the appropriate items).

Difficulty in falling asleep
Difficulty in staying asleep
Nightmare / Unusual dreams
Sleep Walking
Snoring

Waking up too early
Difficulty staying awake during day time
Unusual movements during sleep
Unrefreshed sleep
Bed wetting

SLEEP / DAY SCHEDULE

1. What is your usual bedtime? _____ Get up time? _____
2. About how many hours do you sleep each night? _____
3. How long does it take you to fall asleep? _____
4. About how many times do you wake up each night? _____
5. How long is your longest wake? _____
6. Do you go back to sleep easily after waking in the middle of the night? YES NO
7. What are your work hours: _____
8. Do you work variable / rotating shifts? YES NO
If so, what are they? _____

SYMPTOMS

1. Is your bed partner disturbed by your sleep problem? YES NO MAYBE

2. Do you feel drowsy or sleepy in any of these situations: (please check appropriate items):
 - Eating meals
 - Watching television
 - Reading
 - Driving
 - Talking in a group
 - In church, watching movie / theater / play

3. Does your sleepiness during daytime interfere with your ability to function normally? YES NO

4. Have you ever been involved in an automobile accident due to sleepiness while driving? YES NO

5. Do you take any naps? YES NO

6. Do you snore? YES NO

7. Have you been told that you do any of these in sleep: (check appropriate items)
 - Stop breathing while sleeping
 - Wake up from sleep snorting or choking
 - Walk in your sleep
 - Grind your teeth

8. Do you wake up in the morning with headaches or dry mouth? YES NO

9. Do you feel fresh in the morning when you wake up? YES NO

10. Do you have any problems with sexual functioning? _____

11. Do you experience vivid dream like images while falling asleep or waking from a nap? YES NO

12. Do you dream during naps? YES NO

13. Have you ever felt paralyzed while falling asleep or awakening from a nap? YES NO

14. Have you ever had a feeling of weak knees when you laugh? YES NO

15. Do you experience creeping, crawling, or aching sensations in your legs, or inability to keep your legs still? YES NO If so, does it keep you from falling asleep? YES NO

16. Do you watch a clock, watch television, have racing thoughts, or worry about the next day at the time of falling asleep? YES NO

17. Do you exercise before going to sleep? YES NO

MEDICAL HISTORY

1. Do you have any of these: (check all that apply)

- High blood pressure
- Asthma / emphysema
- Heart attack / Open heart surgery
- Diabetes
- Cancer
- Epilepsy / Seizures / Stroke

2. Do you have any other medical problems

SOCIAL HISTORY

1. How much of these liquids do you drink on a daily basis: (list in cups, cans, etc.)

- _____ Coffee
- _____ Tea
- _____ Soft drinks – caffeinated / caffeine free
- _____ Beer
- _____ Wine
- _____ Liquor

2. Do you smoke on a regular basis? YES NO If yes, how many packs / day _____

MEDICATION HISTORY

1. Do you take any medications including over the counter medications to help you fall asleep or stay awake?

YES NO If yes, list names:

2. List all current medications:

_____	_____
_____	_____
_____	_____

What is your weight now? _____ 6 months ago _____ Two years ago _____

Please print and fax to: Sleep Disorders Institute of Chandler at 480-753-4709