SLEEP QUESTIONNAIRE

CNOS
IMPROVING HEALTH
575 Sioux Point Road
Dakota Dunes, SD 57049

Date:

Name:

Date of Birth: Referring Physician:

Primary Care Provider:

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____

Directions:
It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. **This information will be held in strictest confidence.**

Part 1. Describe in your own words why you are having this study, problems occurring:

Part 2. Habits: List your consumption of the following per day:

Tobacco: Alcohol: Coffee: Tea: Over the counter pills:
How many hours of sleep do you usually get per night?
What time do you usually go to bed on weekdays?
What time do you usually go to bed on weekends?
What time do you usually awaken in the morning on weekdays?
What time do you usually awaken in the morning on weekends?
How long does it take you to fall asleep?
How many times do you typically wake up at night?
If you wake up, how long do you usually stay awake?
What do you usually do when you awaken during the night?
How do you describe your sleep problem? (Check all that apply.) □ Difficulty falling asleep □ Excessive daytime sleepiness □ Wake up during the night □ Difficulty awakening
Do any other members of your family have sleep problems? Please explain.
Do you usually: (Check all that apply) □ Sleep with a bed or room partner □ Provide assistance to someone during the high (child, partner, animal)
When you sleep, are you often disturbed by: □ Heat □ Cold □ Noise □ Light □ Bed partner □ Need to urinate □ Not being in your usual bed □ Other:
Do you do physical exercise within four (4) hours of bedtime: □ Yes □ No
Do you do the following in bed? □ Read □ Smart phone/Electronic device □ Television
How do you feel after an average night of sleep? □ Usually drowsy and/or tired □ Most of the time good □ Consistently good
Do you work split shifts or rotating (variable) shifts? □ Yes □ No If yes, please describe:

Have you consulted with a physician other than your primary provider? For example a cardiologist, pulmonologist or neurologist? If so, what doctors and what for?

Part 3. Medications: Please list all of your medications including supplements and over the counter:

Medication	**Reason for taking:**

Part 4. Please rate how often you:

	Never	**Rarely**	**Sometimes**	**Frequently**	**Constant**
Awaken at night with heartburn, belching, coughing					
Snore					
Wake up gasping for breath during the night					
Have breathing problems at night (observed by self or others)					
Notice your hearting pounding/beating irregularly at night					
Fall asleep during the day					
Fall asleep while driving					
Have trouble at school/work because of sleepiness					
Fall asleep or pass out while laughing or crying					
Experience loss of muscle tone when waking or falling asleep					
Experience vivid dreamlike scenes upon awakening or falling asleep					
Feel afraid to fall asleep					
Have nightmares					
Have anxiety					
Have muscular tension					
Notice parts of your body jerk					
Kick during the night					
Experience crawling and aching in your legs					
Experience any type of leg pain during the night					
Having morning jaw pain					
Grind teeth during the night					
Are awakened by pain					
Wake up with muscle, neck, spine or joint pain					