PHYSICIANS EAST P.A.
Sleep Center
Sleep Well. Live Well.

Patient Name: _____

Date: _____

# Sleep Questionnaire

How long have you had a problem with your sleep? _____

Do you consider your sleep problem to be: ☐ mild ☐ moderate ☐ severe

Do any family members have a sleep problem? ☐ Yes ☐ no

Do you work shifts? ☐ No ☐ Yes If yes, what? ☐ split shift ☐ rotating shift ☐ night shift

Normal bedtime on weekdays: _____ Normal wakeup time on weekdays: _____

Normal bedtime on weekend: _____ Normal wakeup time on weekends: _____

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Do you wake up during the night? |
| Yes ☐ | No ☐ | Do you wake up to go to the bathroom? |
| Yes ☐ | No ☐ | Do you wake up early in the morning? |
| Yes ☐ | No ☐ | Do you have difficulty falling asleep? |
| Yes ☐ | No ☐ | Do you have difficulty staying asleep? |
| Yes ☐ | No ☐ | Do you have difficulty waking up? |
| Yes ☐ | No ☐ | Do you nap during the day/evening? Which one? Day Evening |
| Yes ☐ | No ☐ | Do you dream when you nap? |
| Yes ☐ | No ☐ | Do you have excessive daytime sleepiness? |
| Yes ☐ | No ☐ | Do you have morning headaches? |
| Yes ☐ | No ☐ | Do you awaken short of breath? |
| Yes ☐ | No ☐ | Do you have nighttime heartburn? |
| Yes ☐ | No ☐ | Do you snore? |
| Yes ☐ | No ☐ | Do others complain of your snoring? |
| Yes ☐ | No ☐ | Have you ever awakened choking and gasping for air? |
| Yes ☐ | No ☐ | Have you ever awakened with your heart beating irregularly? |
| Yes ☐ | No ☐ | Have you ever awakened from sweating excessively? |
| Yes ☐ | No ☐ | Have others observed you having breathing problems? |
| Yes ☐ | No ☐ | Do you fall asleep during the day? |
| Yes ☐ | No ☐ | Do you fall asleep during physical effort? |
| Yes ☐ | No ☐ | Do you fall asleep involuntarily? |
| Yes ☐ | No ☐ | Do you fall asleep while laughing? |
| Yes ☐ | No ☐ | Do you fall asleep while crying? |
| Yes ☐ | No ☐ | Do you feel unable to move when waking up or falling asleep? |
| Yes ☐ | No ☐ | Do you experience vivid dream-like scenes upon awakening or falling asleep? |
| Yes ☐ | No ☐ | Do you have trouble at work/school because of sleepiness? |
| Yes ☐ | No ☐ | Do you have nightmares? |
| Yes ☐ | No ☐ | Do you feel sad or depressed? |
| Yes ☐ | No ☐ | Do you feel afraid to go to sleep? |
| Yes ☐ | No ☐ | Do you remember dreams? |
| Yes ☐ | No ☐ | Do you have anxiety? |
| Yes ☐ | No ☐ | Do you feel you won't be able to sleep? |
| Yes ☐ | No ☐ | Do you kick during the night? |
| Yes ☐ | No ☐ | Do you have body pain at night? |
| Yes ☐ | No ☐ | Do you have jaw pain? |
| Yes ☐ | No ☐ | Do you have leg pain? |
| Yes ☐ | No ☐ | Do you have crawling/aching feeling in your legs? |
| Yes ☐ | No ☐ | When you wake up, do you feel stiff? |
| Yes ☐ | No ☐ | When you wake up, do you have a dry mouth? |
| Yes ☐ | No ☐ | When you wake up, do you have sore, achy muscles? |
| Yes ☐ | No ☐ | When you wake up, do you feel tired? |