# Initial Sleep Questionnaire

## Dr DellaBadia Sleep Clinic

**1-866-499-1588**

**Name: _____ Appointment Date_____**

**Date of Birth_____ Age _____ Referring Physician_____**

**Main Sleep Complaint: _____**

**How long has this been going on? _____**

## Section A. Sleep Schedule

(Circle when choices are provided)

**1. What average time do you go to bed? _____**

**2. Average wake up time to start the day? _____**

**3. On the average, how many hours do you sleep each night?** _____ hours

**4. How long does it take to fall asleep?** (_____ mins) **OR** (_____hours) **OR** ranges _____ mins / hours

**5. Do you have trouble falling asleep?** Never / Rarely / Sometimes / Frequently / Always

**6. Do you watch TV in bed while trying to fall asleep?** Never / Rarely / Sometimes / Frequently / Always

**7. Do you read in bed while trying to fall asleep?** Never / Rarely / Sometimes / Frequently / Always

**8. How long does it take to get out of bed to start the day?** (_____ mins) **OR** (_____hours)

**9. How do you feel upon awakening at the start of the day?** Hard to get out of bed / sleepy / tired / groggy / rested / refreshed / other _____

## Section B. Sleep Symptoms

**1. Once asleep, how many times do you wake up during the night?** _____ times **OR** sleeps through night

**2. What wakes you up?** bathroom / unsure / light sleeper / thirst / noise / leg discomfort / pain (list type of pain below)

_____

**3. If you wake up during the night, how long does it take to fall back asleep?** (_____ mins) **OR** (_____hours)

**4. Do you snore?** Never / Rarely / Sometimes / Frequently / Always

- **a. If yes, how long have you been snoring?** (_____ months) **OR** (_____years) **OR** (I don't know)
- **b. If yes, how loud is it?** Mild / moderate / loud / very loud / I don't know
- **c. Is there a position that makes it worse than others?** Back / side / stomach / NO / I don't know
- **d. Has the snoring awakened you from sleep?** YES / NO
- **e. Can you snore while asleep sitting up?** YES / NO

**5. Do you awaken from sleep gasping or choking?** Never / Rarely / Sometimes / Frequently / Every night

**6. Has anyone noticed that you stop breathing when you are asleep?** YES / NO

**7. Do you awaken with a headache in the morning?** Never / Rarely / Sometimes / Frequently / Always

**8. How many pillows do you sleep on?** _____ pillow(s)

**9. Can you sleep flat on your back?** YES / NO; **if no, why not** _____

**10. Do you wake up from sleep with heartburn?** Never / Rarely / Sometimes / Frequently / Always

**11. Do you wake up from sleep very sweaty?** Never / Rarely / Sometimes / Frequently / Always

**12. Do your legs jerk while asleep?** Never / Rarely / Sometimes / Frequently / Every night / Don't know

**13. How often do you have leg cramps at night?** Never / Rarely / Sometimes / Frequently / Every night

**14. Does leg discomfort (not arthritis or joint discomfort) ever wake you from sleep?** Never / Rarely / Sometimes / Frequently / Every night

**a. If yes, how long has this been going on?** (_____ months) **OR** (_____years)

**b. If yes, describe the discomfort: pins & needles / aching / throbbing / toothache feeling / creepy crawly** Other _____

**c. If yes, what part of your body is affected?** Both legs / left leg / right leg

**d. If yes, where?** Above the knee / below the knee / entire leg

**e. If yes, does this ever bother you during the day?** Never / Rarely / Sometimes / Frequently / Every day

**15. Do you sleep walk?** Never / Rarely / Sometimes / Frequently / Every night

**16. Have you ever eaten while asleep?** Never / Rarely / Sometimes / Frequently / Every night

**17. Do you ever awaken from sleep and feel paralyzed?** Never / Rarely / Sometimes / Frequently / Every night

**18. Do you have life-like dreams while you are falling asleep at the beginning of the night?** Never / Rarely / Sometimes / Frequently / Every night

## Section C. Daytime Sleep Related Symptoms

**1. Do you feel sleepy during the day?** Never / Rarely / Sometimes / Frequently / Every day

**If yes, how long has this been going on?** (_____ months) **OR** (_____years)

**2. Are you likely to fall asleep during the day when:** (circle all that apply) None / Inactive / watching TV / eating / standing / talking to other people / driving / working

**3. Have you ever had a car accident due to sleepiness?** YES / NO (When _____)

**4. Do you take naps during the day?** Never / Rarely / Sometimes / Frequently / Every day

**a. If yes, how many naps do you take in a typical.?** (day? _____) **OR** (week? _____) **OR** (month? _____)

**b. If yes, the naps are:** planned / unplanned / both planned and unplanned

**c. If yes, how long do the naps last?** (_____ mins) **OR** (_____ hours)

**d. If yes, how do you feel after a nap?** better / the same / worse / sometimes better and sometimes worse

**5. Do you use caffeine to help stay awake?** YES / NO

**6. During the day, do you have poor concentration?** Never / Rarely / Sometimes / Frequently / Daily

**7. During the day, do you have memory problems?** Never / Rarely / Sometimes / Frequently / Daily

**8. During the day, do you feel irritability & short-tempered?** Never / Rarely / Sometimes / Frequently / Always

**9. When laughing or excited, do you suddenly fall and are unable to move?** Never / Rarely / Sometimes / Frequently / Always

**a. If yes, how often?** (_____ times per day) **OR** (_____ per week) **OR** (_____ per month)

## Section D. Review of Systems

**[CIRCLE ALL THAT CURRENTLY APPLY]**

**1. Constitutional?**
Fever
Chills
Systemic Illness
Night Sweats
Recent Fatigue
Poor Appetite
Weight Gain OR Loss
of ____ lbs in ____months
Other_____
_____

**2. Eye Symptoms?**
Diminished vision
Blurry vision
Double vision
Blind spots
Eye pain
Eye Infection
Itchy eyes
Other_____
_____

**3. ENT Symptoms?**
Nose bleed
Loss of Smell
Nasal Congestion
Sinus Congestion
Nasal Obstruction
Post Nasal Drip
Runny Nose
Sinus Infection
Dryness of Mouth
Difficulty swallowing
Dizziness
Ringing in the Ears
Hearing Difficulty
Hearing Loss
Hoarseness
Sore Throat
Other_____
_____

**4. Cardiovascular?**
Fainting
Lightheadedness
Chest Pain
Ankle Swelling
Heart racing
Irregular heart beat
Other_____
_____

**5. Respiratory?**
Cough
Productive Cough
Coughing up blood
Difficulty breathing
Wheezing
Shortness of breath-
at rest
with exertion
upon lying down
Rib Pain
Other_____
_____

**6. Gastrointestinal?**
Bloating
Indigestion
Heartburn
Nausea
Vomiting
Abdominal Pain
Constipation
Diarrhea
Food Intolerance
Other_____
_____

**7. Genitourinary?**
Difficultly Voiding
Urinary hesitancy
Urinary urgency
Incontinence
Pain with urination
Blood in urine
Urinating many times a night
Urinary tract Infection
Kidney Stones
Women-- Abnormal menstrual cycle
Ovarian Cysts
Men-- Prostate Problems
Other_____
_____

**8. Musculoskeletal?**
Joint Nodules
Joint stiffness
Morning Stiffness
Joint Swelling
Neck Pain
Hip Pain
Back Pain
Decreased Range of Motion
General Weakness
Weakness on one side of the body
Other_____
_____

**9. Neurologic?**
Lack of coordination
Falling
Tremor
Dizziness
Loss of consciousness
Seizures
Decreased memory
Numbness / Tingling:
Where?_____
Migraines
Headaches:
Other_____
_____

**10. Psychiatric?**
Anxiety
Delusions
Disorientation
Depression
Mood Swings
Hallucinations
Paranoia
Suicidal thoughts
Other_____
_____

## Section E. Medications

**1. Do you have any medication allergies?** No/ Yes, list:_____

**2. List any medications used for sleep:**_____

**3. List current medications**

_____
_____
_____
_____
_____

## Section F. Past Medical History

AIDS or HIV
Alcohol Abuse
Drug Abuse
Fibromyalgia
Anemia
Angina
Arthritis
Asthma
Benign Tumor:
Type- _____
Bleeding disorder
Bronchitis
Cancer: Type- _____
Carpal Tunnel Syndrome
Congestive Heart Failure
COPD
Emphysema
Coronary Artery Disease
Crohn's Disease
Degenerative Disc Disease
Depression
Diabetes Insulin Dependent
Diabetes Non-Insulin
Disc Injury
Disc herniation
Dizziness
Fainting
Gall Bladder Disease
Gastric acid reflux
Gout
Headache
Heart Arrhythmia
Heart Attack
Heart Disease
Heart Palpitations
Hepatitis A B C
Hypertension
High Cholesterol
Hyperthyroidism
Hypothyroidism
Incontinence
Kidney Disease
Liver Disease
Lupus
Migraines
Mitral Valve Prolapse
Multiple Sclerosis
Narcolepsy
Neuropathy
Obesity
Obstructive Sleep Apnea
Osteoporosis
Parkinson's Disease
Pneumonia
Restless Leg Syndrome
Schizophrenia
Seizure / Epilepsy
Sickle Cell Disease
Sinus Disease
Stomach Ulcer
Stroke
Syncope

Other: _____

## Section G. Past Surgical History

Amputation: _____
Appendectomy
Bowel Resection
Coronary Artery Bypass
Cardiac Catheterization
Cardiac valve repair
Pacemaker Implantation
Cataract surgery
Cholecystectomy
Gastric Band
Gastric Bypass
Hip Replacement (RT / LT)
Knee replacement (RT/LT)
Hysterectomy
Nasal Surgery
Sinus Surgery
Tonsillectomy
Adenoidectomy
Uluveopalatopharyngeo-plasty

Other _____

## Section H. Social History

**1. Marital Status?** Single / Married / Separated / Divorced / Widowed / Significant other

**2. Have you ever smoked at least 100 cigarettes in your entire life?** No/ Yes

**3. Current smoking status:** Every day smoker / Some day smoker / Former smoker / Never smoked

**4. Do you use alcohol?** No/ Yes How Much_____ How often_____ For How Long_____

**5. Do you use illegal drugs?** Never / In the past / Currently. What type_____

**6. Your occupation? _____**

**7. Number of Children? _____**

## Section I. Family History

**1. Does any family member have…? (If so, who?)**
***sleep apnea _____narcolepsy_____ restless leg syndrome_____***

**2. List any major illnesses in the family:**

**Mother _____**

**Father _____**

**Siblings _____**

**Children _____**