Follow-Up Sleep Questionnaire

Dr DellaBadia Sleep Clinic

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Name: _____ Appointment Date_____

Date of Birth_____ Age _____ Referring Physician_____

Main Sleep Complaint: _____

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

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 / Pets / leg discomfort / pain
If pain, describe type of pain. _____

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

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

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

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

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

2. 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)

3. 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

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, how long do the naps last? (_____ mins) **OR** (_____ hours)

c. 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. 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)

7. When laughing or excited, do you get weak in the knees? Never / Rarely / Sometimes / Frequently / Always

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

Section D. Restless Leg Syndrome (SKIP TO SECTION E. IF NOT APPLICABLE)

1. Overall, when present, how would you rate the severity of the restless leg symptoms?

Resolved / mild / moderate / severe

2. How often do you get restless leg symptoms?

Never / Less than 1 week / 2-3 times a week / 4-5 times a week / Every night

3. On the days when the symptoms are present, how long do they last?

Less than one hour a day / 1-3 hours a day / 3-8 hours a day / over 8 hours a day

4. Compared to your last visit, are the symptoms: slightly better / better / the same / slightly worse / much worse

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

6. Which medication are you using? Mirapex / Requip / Iron / Neurotin / Other _____

7. Is the medication helping? Yes, symptoms have resolved / a little / somewhat / a lot

Section E. 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 F. Medications

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

2. List any medications used for sleep:_____

3. List current medications _____

_____

_____

_____

_____

Section G. Past Medical History

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

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

3. Any new medical/surgical problems since your last visit? No/ Yes If yes, _____

_____