Sleep Medical Centers
Consultations, Testing, Equipment
Your All-In-One Sleep Solution
Call 919-477-1588 / 866-499-1588
Fax 919-477-1688 / 866-499-1288

PSG Bedtime Questionnaire

Name: ______________________________ **Date:** ________________

Please list your current medications including the dose ______________________________

____

Do you have any physical complaints right now? ______________________________

Nighttime Sleep Pattern

Do you have trouble falling asleep? Y / N If yes, why ____________

Usual bedtime ____________ How long does it take to fall asleep? ____________

How many times do you wake up at night? ______ How long does it take to fall *back* to sleep? ________

Usual hours of sleep each night? ____________ Do you have trouble waking up in the morning? Y / N

Usual wake-up time ____________ Usual time that you get out of bed ____________

Do you snore? Y / N If yes (circle) - soft / medium / loud / very loud

Do you wake up gasping for air? Y / N Have you been told you stop breathing while asleep? Y / N

Is your sleep restless? Y / N Do you toss and turn? Y / N or sleep soundly? Y / N

Do your legs jerk or twitch during the night? Y / N Do your legs feel uncomfortable or have an urge to move? Y / N

Do you have vivid lifelike dreams while falling asleep? Y / N

How many naps do you take per day? _____ Usual length of nap? _____ Did you nap today? Y / N How long? _____

Social History

Do you drink caffeinated beverages? Y / N Type ____________ How much? ________

Do you use tobacco? Y / N How much ________ How long? ________

Do you use alcohol? Y / N How much ________ How long? ________

Marital status: S, M, D, W Occupation:________________ Work hrs: __________ Alternate shifts? Y / N

Prior Sleep Evaluation

Have you ever been diagnosed with a sleep disorder? Y / N What? ____________________

Have you ever had an overnight sleep study? Y / N Year (approximate) ________________

Are you currently using (circle): CPAP / BiPAP About how many years ______ New machine needed? Y / N

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

SCALE **0** = Never Doze **1** = Slight Chance of Dozing **2** = Moderate Chance of Dozing **3** = High Chance of Dozing

SITUATION	Chance of Dozing (0-3)
Sitting and reading	________
Watching TV	________
Sitting in a public place (e.g. theater, meeting)	________
As a passenger in a car for an hour	________
Lying down to rest in the afternoon	________
Sitting and talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car while stopped for traffic	________