NMCSD Sleep Disorders Center
Sleep Questionnaire for Adults
Ver. 1.2 18-12-12

The information you are being asked to provide is VERY important and will assist us during the review of your sleep study. Please respond to all questions.

Note- if you do not know the answer please write "I don't know". If the question does not apply to you please write "N/A", do not leave it blank. Let us know if you need help with any question.

Contact Information in case we need to talk to you about your sleep study or to order treatment

Last Name: _____ **First Name:** _____
Home address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone #: _____ **Cell Phone #:** _____
Work Phone#: _____ **E-mail:** _____

PERSONAL

Date of Birth: _____ **Age:** _____ **years** **Gender: Male** ☐ **Female** ☐

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Race/Ethnicity
- ☐ African American
- ☐ White
- ☐ Asian/ Pacific Islander
- ☐ Hispanic/Latino
- ☐ Other

Years of Schooling
- ☐ Less than high school
- ☐ Finished high school
- ☐ Less than 4 years of college
- ☐ 4 years of college
- ☐ More than 4 years of college

SLEEP PROBLEMS (please check all that apply)

- ☐ Snoring
- ☐ Sleepy during the day
- ☐ Gasping/ Choking while asleep
- ☐ Breathing pauses while asleep
- ☐ Unrefreshing Sleep
- ☐ Other
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Tired during the day
- ☐ Morning Headache
- ☐ Unusual behavior in sleep (walking, talking, acting out dreams)

SLEEP HABITS

	Work Day	Non-work day
1. What time do you get into bed?	____ am ☐ pm	____ am ☐ pm
2. What time do you turn off the lights to go to sleep?	____ am ☐ pm	____ am ☐ pm
3. What time do you get out of bed to start the day?	____ am ☐ pm	____ am ☐ pm
4. How many hours do you actually spend in bed?	_____	_____
5. How many hours do you think you actually sleep?	_____	_____

6. On average, how long does it take you to fall asleep?
   - ☐ 5 minutes or less
   - ☐ 5-30 minutes
   - ☐ 30 minutes-1 hour
   - ☐ 1-2 hours
   - ☐ more than 2 hours

7. How often do you wake up during the night?

Frequently	Occasionally	Never	Don't know
☐	☐	☐	☐

8. How often do you use a sleep aid (prescribed medication or over the counter) or alcohol to help you fall asleep?
   - ☐ never
   - ☐ 1-2 times/ month
   - ☐ 1-2 times/week
   - ☐ 3-5 times/week
   - ☐ every night

   What type of sleep aid do you use?_____

HEIGHT AND WEIGHT

What is (was) your body weight

Now	_____ pounds
6 months ago	_____ pounds
At age 20	_____ pounds
At heaviest	_____ pounds

What is your height _____feet _____inches

SLEEPINESS INDEX

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how that would have affected you. Choose the most appropriate answer for each situation

	High Chance of dozing	Moderate Chance of dozing	Slight Chance of dozing	Would never doze
a. Sitting and reading				
b. Watching TV				
c. As a passenger in a car for 1 hour without a break				
d. Sitting inactive in a public place (theater, meeting)				
e. Lying down to rest in the afternoon when circumstances permit				
f. In a car, stopped for a few minutes in traffic				
g. Sitting quietly after lunch without alcohol				
h. Sitting and talking to someone				

SLEEP MEDICAL HISTORY

Note: If you do not know the answer, please write, "I don't know", do not leave blank.

Have you had a previous Sleep Study? Yes ☐ No ☐
If so, when and where?
_____

Which of these sleep disorders have you even been diagnosed with or treated for? (check all that apply)

- ☐ Obstructive sleep apnea
- ☐ Central Sleep Apnea
- ☐ Insomnia
- ☐ Restless legs Syndrome
- ☐ Periodic limb movement disorder
- ☐ Narcolepsy
- ☐ Other: _____

If you have received treatment for sleep apnea, what sort of treatment did you have? (check all that apply)

- ☐ CPAP
- ☐ Surgery
- ☐ Dental appliance
- ☐ Other: _____

If you are on CPAP or Bi-PAP, what is your current pressure? _____
How often do you use CPAP or Bi-PAP? _____
Do you use oxygen at night? Yes ☐ No ☐

GENERAL MEDICAL HISTORY

Please check all that apply in the boxes beside the medical problems that you have now or have had in the past or write in the empty space provided.

- ☐ Hypertension/High blood pressure
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Allergies/nasal congestion/sinusitis
- ☐ Congestive heart failure
- ☐ Heart disease (angina, heart attack)
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Stroke
- ☐ Migraine
- ☐ Seizures/epilepsy
- ☐ Anxiety disorder diagnosed by physician
- ☐ Depression diagnosed by physician
- ☐ Panic disorder
- ☐ Heartburn/Acid reflux
- ☐ Arthritis
- ☐ Hypothyroid
- ☐ Throat surgery for sleep apnea (UPPP)
- ☐ Dementia
- ☐ Parkinson's disease

Other medical problems (please write them below):

Medications ☐ I am currently not taking any medications.
If you are taking medications, please list all of them (prescription or over-the-counter)

List of medications

_____
_____
_____
_____
_____