

Central Utah Sleep Disorders Center-Sleep Questionnaire

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Neck Size: _____

Referring Doctor _____ Family Doctor _____

What is your normal bedtime? _____ What time do you normally get up? _____

How many days a week do you take a nap? _____ If you nap, about how long is each nap? _____

About what percent of the night do you sleep on your back? _____

How many times do you get up at night to use the restroom? _____

Do you have any nighttime pain or discomfort? Yes No

If so, please briefly describe _____

How much weight have you gained or lost in the last year? _____ Last 3 years? _____

Is there a family history of sleep disorders? Yes No

If so, who and what kind of disorder _____

PLEASE CHECK THOSE WHICH APPLY TO YOUR SITUATION

- | | |
|---|--|
| <input type="checkbox"/> Shift Work | <input type="checkbox"/> I snort, choke or gasp while asleep |
| <input type="checkbox"/> Limb movements/twitches while asleep | <input type="checkbox"/> Frequent difficulty waking up |
| <input type="checkbox"/> Non restorative sleep | <input type="checkbox"/> Difficulty staying awake at work |
| <input type="checkbox"/> Frequent daytime fatigue | <input type="checkbox"/> Wake up with morning headaches |
| <input type="checkbox"/> Breathing pauses during sleep | <input type="checkbox"/> Difficulty staying awake while driving |
| <input type="checkbox"/> Crawling sensations on legs | <input type="checkbox"/> Wake up with dry mouth/sore throat |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Muscle Weakness when suddenly excited or startled |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Feelings of depression |
| <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Sleepwalking or other "bizarre" sleep behavior |
| <input type="checkbox"/> Frequent snoring during sleep | <input type="checkbox"/> Cigarette smoker |
| <input type="checkbox"/> Use sleeping pills | <input type="checkbox"/> Wake up unable to move |
| <input type="checkbox"/> Loud snoring during sleep | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Use alcohol to aid in sleeping | |
| <input type="checkbox"/> My snoring has awakened me | |

PLEASE CHECK THE CONDITIONS WHICH YOU HAVE BEEN DIAGNOSED WITH

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Water Retention | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | _____ |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | _____ |
| | <input type="checkbox"/> Low Thyroid Levels | |