NEWTON WELLESLEY NEUROLOGY ASSOCIATES
SLEEP QUESTIONNAIRE

Please fill out this form pertaining to your medical and sleep history and bring it with you to your appointment

LAST NAME:_________________________________FIRST: ____ DOB: ________________
WEIGHT: __________LBS HEIGHT: ______FT _______IN NECK CIRCUMFERENCE: ____________ IN
WORK SCHEDULE (CHECK ALL THAT APPLY) ___ DAY __NIGHT __ ROTATING __SELF EMPLOYED __RETIRED/UNEMPLOYED

PRIMARY COMPLAINT (check all that apply)
__Snoring and/or stop breathing at night
__ Tired/sleepy during the day
__ Difficulty falling or staying asleep
__ Unusual behavior(s) during sleep (walking, talking, etc.)

PREPARING FOR SLEEP Answer the following questions with respect to the last 30 days
On average, how long does it usually take to fall asleep at night? ____
If it usually takes more than 30 minutes to fall asleep, please indicate when this started:
___ During the last 3 months
__ More than 3 months ago but less than 1 year ago
___ More than 1 year ago
__ Following an event that occurred ___ months/years ago
Describe the event that preceded difficulty sleeping, (if applicable): ____

Which of the following do you notice when trying to fall asleep:	NEVER	OCCASIONALLY	FREQUENTLY
• Coughing, difficulty breathing, or feeling of suffocation	___	___	___
• Sensation of heat or sweating	___	___	___
• Headache	___	___	___
• Anxiety, worry, or disturbing thoughts	___	___	___
• Rapid heartbeat	___	___	___
• Pain (legs, neck, chest, stomach, other)	___	___	___
• Need to move legs	___	___	___
• Twitches in hands, feet, arms, legs	___	___	___
• Heartburn, acid reflux, GERD	___	___	___
• Do you wake yourself up because of snoring	___	___	___

SLEEP HABITS	WEEKDAYS	WEEKENDS
What time do you turn off the lights to go to sleep?	_____AM/PM	_____AM/PM
What time do you get out of bed to start the day?	_____AM/PM	_____AM/PM
How many hours do you think you actually sleep ?	_____HOURS	_____HOURS
How many hours do you spend between bedtime and waking?	_____HOURS	_____HOURS

Do you often wake in the middle of the night? ___YES ___NO
If yes, how often ___every night ___1-2 times per week ___3 or more times per week
What awakens you? ____
What do you do when awake? ____

Has anyone ever told you that you:	NEVER	OCCASIONALLY	FREQUENTLY
• Snore	___	___	___
• Stop breathing or gasping for air	___	___	___
• Kick, jerk or twitch your legs during sleep	___	___	___
• Grind your teeth while sleeping	___	___	___
• Shout out during sleep	___	___	___
How do you feel when you wake in the morning?			
• Tired (want to continue sleeping)	___	___	___
• Refreshed and energetic	___	___	___
• Unpleasant dry mouth	___	___	___
• Suffer from pain or stiffness	___	___	___

In which position do you sleep ? ___ Stomach ___ Back ___Side ___Raised/sitting ___No fixed position
Have you ever been diagnosed or treated for a sleep disorder? ___ Yes ___ No
Approximately how many 8 oz cups of caffeinated beverages (coffee, tea, soda) do you drink daily? _______________
When do you typically drink your last cup of caffeinated beverage each day? _______________ AM/PM

(please continue on other side of form)

How many alcoholic beverages do you drink daily? _______________ Do you smoke? _____Yes _____ No
If yes, how many cigarettes do you smoke daily?: __________ How long have you been a smoker? ________________
As a result of sleepiness, have you personally experienced any of the following?

- Auto accident with injury to yourself or others? _____ Yes _____ No
- Auto accident without injury? _____ Yes _____ No
- Work related accident? _____ Yes _____ No

In your own words please describe your sleep related problem (brief summary)
____
____
____
____

DAYTIME ACTIVITY

In the last 30 days, how likely were you to doze off or fall asleep in the following situations?

	HIGH CHANCE	MODERATE CHANCE	SLIGHT CHANCE	NEVER DOZE
• Sitting and reading	__	__	__	__
• Watching TV	__	__	__	__
• Sitting inactive in a public place (e.g. theater, church)	__	__	__	__
• As a passenger in a car for an hour with no break	__	__	__	__
• Lying down to rest in afternoon	__	__	__	__
• Sitting and talking to someone	__	__	__	__
• Sitting quietly after lunch (without alcohol)	__	__	__	__
• Driving a car	__	__	__	__

Do you ever have sudden muscular weakness associated with emotion? __ Yes __ No
Do you participate in vigorous physical activities regularly? __ Always __Often __ Never

HEALTH From which of the following medical conditions do you suffer? (check all that apply):

__ DIABETES
__ Asthma
  __Nocturnal
  __Allergic
  __ Other: ____________________
__ KIDNEY DISEASE:
  __ Dialysis
  __ Renal Insufficiency
  __Other: ___________________
__ GASTROINTESTINAL OR LIVER DISEASE
__HYPERTENSION
__ ARTHRITIS
__MENTAL ILLNESS:
  __Depression
  __Anxiety
  __ Panic Disorder
  __ Schizophrenia
  __ Other: ____________________
__ NASAL CONGESTION
  __ One Nostril
  __ Both Nostrils
__ THYROID DISEASE:
  __ Hyperthyroid
  __ Hypothyroid
  __ Other:_______________
__HEART DISEASE
  __Coronary Artery Disease
  __Heart Attack/Angina
  __Congestive Heart Failure
  __ Irregular Heart Beat
  __ Pacemaker
__LUNG DISEASE
  __Emphysema
  __ Chronic Bronchitis
  __ Lung Cancer
  __ Other: _______________
__NEUROLOGICAL DISORDER
  __ Stroke
  __ Seizures
  __Migraine Headaches
  __ Other: _______________________
__ DOWNS SYNDROME
__CRANIOFACIAL ABNORMALITIES

Have you had any surgery in the last 6 years? __ Yes __ No
If yes, please explain____

WOMEN ONLY: ___Regular Periods ___Menopausal __ Other:____

____ ____________________________
Patient/Guardian Signature *Date*