SHORE PULMONARY, PA
SLEEP DISORDER QUESTIONNAIRE

NAME:_____DATE:_____

1. Why are you seeking treatment at this time? _____

   _____

2. Is there any aspect of your sleep environment that seems to contribute to your sleep Problems?_____

   _____

3. What is your neck size?_____
4. What is your usual bedtime (the time you get into bed)?_____
5. What is your usual rise time (the time you get out of bed)?_____
6. Does your bedtime and rise time fluctuate from day to day?_____
7. Do you change your bedtime and rise time on the weekends or on days that you do Not work?_____ If yes, what is your usual bedtime on weekends or non-work days_____, what is your usual rise time on weekends or non-work days_____
8. How long does it usually take you to fall asleep after you get into bed?_____
9. How many times do you usually awaken during the sleep period?_____
10. What is the average duration of your awakenings?_____
11. On the average, how long would you say you actually are asleep each night?_____
12. Do you have a regular nightly routine that you follow every night before getting into Bed?_____ If yes, what do you usually do?_____

    _____

13. Do you read, watch tv, or engage in other activities while in bed before sleep onset? If yes, please explain_____

    _____

14. Do you usually feel sluggish, sleepy or fatigued upon awakening in the morning? ____yes _____no
15. Do you usually feel fatigued throughout the day? ____yes _____no

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16. Do you have difficulty functioning at work due to fatigue? ____yes _____no
17. Do you tend to fall asleep at inappropriate times? ____yes _____no

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18. Have you had a motor vehicle accident due to sleepiness or fatigue? ___yes ____no
19. Do you usually nap during the day? ____yes ____no
20. Do you usually have difficulty falling asleep at the beginning of the sleep period? period? ____yes ____no
21. Do you wake up too early and find that you can't return to sleep? ____yes ____no
22. Do you snore? ____yes ____no
23. Have you awakened yourself or someone else with snoring sounds? ___yes ____no
24. Has anyone ever told you that you seem to have difficulty breathing or that you stop breathing during sleep? ____yes ____no
25. Do you ever awaken with the sensation of shortness of breath? ____yes ____no
26. Do you ever awaken gasping, choking, or "gulping for air?" ____yes ____no
27. Do you often awaken with a dry mouth or sore throat? ____yes ____no
28. Do you ever awaken with headaches? ____yes ____no
29. Have you had surgery for snoring or sleep apnea? ____yes ____no
30. Have you ever experienced "sleep attacks" (sudden, irresistible urge to sleep)? ____yes ____no
31. Upon falling asleep or waking up have you ever had the experience of being unable to move your arms or legs, even if you try? ____yes ____no
32. Have you ever done things during the day without having awareness of your actions? actions? ____yes ____no
33. Have you ever experienced sudden muscle weakness while awake (in mild conditions this could be experienced as a weak grip, or leg or arm weakness). In severe conditions, one's legs might buckle and the person might fall to the floor? ____yes ____no

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34. Do you experience painful or unusual sensations of your legs while at rest, especially in the evening? ____yes ____no
35. Do you ever experience "twitching" or "jerking" of your feet or legs while asleep? ____yes ____no

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36. Are you a shift worker (evenings, nights, or rotating shifts)? ____yes ____no
37. Do you suffer from jet lag? ____yes ____no
38. Do you find that you typically fall asleep earlier than desired and awaken earlier than desired? ____yes ____no
39. Do you find that you typically fall asleep later than desired and awaken later than desired? ____yes ____no
40. Have you now, or have you ever in the past, received treatment for high blood pressure? ____yes _____no
41. Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? arrhythmia? ____yes _____no
42. Have you ever suffered a stroke? ____yes _____no
43. Have you ever suffered a heart attack? ____yes _____no