



Please Arrive 15 Minutes Before Your Scheduled Appointment Time
Pinehurst Medical Clinic Sleep Medicine Questionnaire

Name: _____ Date: _____

Referring Doctor: _____

Why are you seeing a sleep specialist: _____

Please help us find out about you by filling out the "Patient" side of this form

PATIENT	CLINICIAN
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When did your sleep issues begin? _____

Any trouble sleeping as a child or teenager? Yes No

If you have tried any sleep medications which ones?

Are you currently using a sleep aid and which one? _____

Tell us about your sleep schedule:

What is your weekday bedtime? _____ wake up? _____

weekend bedtime? _____ wake up? _____

How long does it take for you to fall asleep? _____ minutes _____ hrs.

What time do you eat dinner? _____

What snacks/drinks do you typically consume after dinner?

What do you do after dinner? _____

Do you do any of the following activities **in bed** before bedtime?

Circle all that apply: read watch TV play video games

talk on phone use cell phone , tablet or computer

How many times do you wake up in the middle of the night? _____

able to fall back to sleep easily? Yes No Not always

How often do you need to get up to urinate during sleep? _____

What do you do when you are unable to sleep? _____

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Do you work outside the home? Yes No

If yes, what are your hours? _____

Do you work weekends? Yes No Shift Work? 1st 2nd 3rd

Retired? Yes No

Disabled? Yes No

BMI > 35

Age >50

Neck:

Gender:

Mallampati:

Do you take daytime naps? Yes No

How many per week? _____

How long do they last? _____

What time of the day? _____

Are the naps refreshing? Yes No

Do you doze (unintentional falling asleep) in the afternoon or evening?

Yes No

Do you ever experience restlessness in your legs before bedtime?

No Yes: how many days per week? _____

If yes, Does it disrupt your sleep ? Yes No

Do you move or kick you legs while sleeping? (*Bed partner complains*)

Yes No Don't know

Currently smoking?

Yes No

Do you drink alcohol beverages routinely at night? ?

Yes No

If yes, how many? _____

Do you drink caffeinated beverages (coffee, tea, soda)? Yes No

How many before 6pm? _____ How many after 6pm? _____

Do you drink any type of energy drinks?

Yes No

If yes, how many and what times? _____

If you use any recreational drugs, please list: _____

Have you ever felt the sudden loss of strength (arms/legs) in response to emotional experiences?

Yes No

Have you ever felt paralyzed when you first wake up or when falling asleep?

Yes No

Do you ever have vivid or menacing visions while you are falling asleep?

Yes No

Do you walk in your sleep?

Yes No

Talk in your sleep?

Yes No

Do you have nightmares?

Yes No

Do you ever accidentally urinate in bed?

Yes No

Are you sleepy or tired during the day? Yes No

How many days of the week? _____

When did it start ____weeks ____months ____years

Is it worsening? Yes No

Have you had close calls or accidents when driving due to sleepiness?

Yes No

Have you had any issues with concentration or memory loss?

Yes No

