Sleep Questionnaire

Patient Label Here

Name: _____ **Birthdate:** _____

Please complete the following questions. This will help our providers understand your sleep habits.

What are your typical work hours? _____

What time do you go to bed? _____ What time do you wake up? _____

How long does it take you to fall asleep? _____

Do you stay asleep all night? Yes No

If not, how many times a night do you wake up? _____

What wakes you up? _____

Please answer the following questions:

Please check Yes Or No	**Yes**	**No**
Do you feel rested in the morning?		
Do you feel like you get enough sleep?		
Do you feel sleepy during the day?		
Are you tired or lack energy during the day?		
Do you snore?		
Do you wake up gasping or short of breath?		
Are you a restless sleeper?		
Do you talk in your sleep?		
Do you sleep walk?		
Do you act out your dreams?		
Do you grind your teeth?		
Do your get weak or feel paralyzed when you laugh, get angry or feel extreme emotion?		

Sleep Questionnaire

Do you find yourself dozing off with the following activities?

Please check Yes Or No	**YES**	**NO**
Reading		
Watching TV		
Driving		
As a passenger in a car		
Sitting after lunch		
Sitting inactive in a public place		

Have you ever had a sleep study before? Yes No

Please bring a copy of your sleep study if it was not done at LGH

Do you drink caffeine? Yes No If yes, how much per day? _____

Do you use illicit drugs? Yes No If yes, what and how often? _____

Do you drink alcohol? Yes No If yes, how much and how often? _____