

SLEEP DISORDERS CENTER – SLEEP QUESTIONNAIRE

Please circle all questions that you would answer with **YES**.

1. SLEEP LOSS

- a. Do you have difficulty falling asleep?
- b. Do you awaken too early in the morning?
- c. If you wake up in the middle of the night, do you have problems falling back to sleep?
- d. Do you feel tired when you awaken in the morning?
- e. Do you feel like your tiredness is affecting your mood during the day? Do you feel tense, irritable, or depressed?
- f. Do you work second or third shift?
- g. Do you drink caffeine or alcohol within three hours before bedtime?
- h. Is your sleep disturbed due to frequent travel?
- i. Do you wake up many times, at times to use the bathroom or do you ever wet the bed?

2. DAYTIME SLEEPINESS

- a. Do you fall asleep at unpredicted times?
- b. Does sleepiness interfere with your social life?
- c. During a 24-hour period, do you sleep more than 9 hours?
- d. Do you snore heavily?
- e. Have you been told that you have pauses in your breathing while you sleep?
- f. Do your muscles feel very weak when laughing, excited or angry?
- g. Do you have trouble concentrating or remembering things during the day?
- h. Do you awaken from sleep feeling paralyzed?
- i. Do you see, hear, or feel things when you are falling asleep?

3. NIGHT TIME DISTURBANCE

- a. Do your legs feel uncomfortable, restless, or tingle before or during sleep?
- b. Have you recently walked in your sleep?
- c. Do you have nightmares?
- d. Have you recently fallen out of bed?
- e. Have you had any accidents or near accidents because of excessive sleepiness?
- f. Do you awaken in the morning with a headache?
- g. Do you have night sweats?
- h. Are you a restless sleeper?
- i. Do you awaken from sleep screaming, violent, or confused?
- j. Have you been told that you thrash violently in your sleep?
- k. Do you talk in your sleep?
- l. Do you wake with bad heartburn or sour taste in your mouth?

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SDC – Sleep Questionnaire

FR-45-SLEEP LAB – REV. 12/2005

PATIENT IDENTIFICATION
1 1/4" X 3"

What time did you wake up today? _____ am/pm
What time do you usually wake up? _____ am/pm

Has anything out of the ordinary happened to you recently? If yes, what? _____

Did you take a nap today? If yes, how long? _____
What time did you last eat? _____ Was it a meal or snack (circle one)?
Do you smoke? If yes, when did you have your last cigarette? _____
Have you had any alcoholic beverages today? If so, when? _____ How much did you
drink? _____ What did you drink? _____

Have you used any medications today? Please list all medications.

Medication & Daily dosage	Time Taken	Medication & Daily dosage	Time Taken

Will you take any additional medications before bed tonight? If yes, what? _____

Do you have physical discomfort at the present time? If yes, what? _____

Are you worried about sleeping in the sleep lab? (circle one)
Not at all Slightly Moderately Very much

Advanced Directives

Do you need more information on Advanced Directives or Living Wills? _____ Yes _____ No
Do you have Advanced Directives? _____ Yes _____ No
Do you have a Living Will? _____ Yes _____ No
If yes, a copy is requested for Sleep Disorder Center. If you brought it with you please let us know.

Date: _____ Reviewed by: _____

