



## Polysomnography Patient Questionnaire

Date \_\_\_\_\_

Medical Record # \_\_\_\_\_

### **Demographics:**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Please complete each section of this questionnaire, answering all questions whether or not they seem applicable to your complaints. Bedpartner assistance will be needed to answer some of the questions.

Briefly describe your sleep problem or the reason for referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Lifestyle:**

Does your job require that you change shifts? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

How often do you travel across time zones? \_\_\_\_\_ times per month

For each of the beverages listed below, write in the average number you drink per day:

Caffeinated coffee \_\_\_\_\_ cups per day

Tea \_\_\_\_\_ cups per day

Soft drinks \_\_\_\_\_ cans or bottles per day

How late in the day do you drink caffeinated beverages? \_\_\_\_\_

On the average, how many alcoholic beverages do you drink on the weekend? \_\_\_\_\_ drinks per day  
on weekdays? \_\_\_\_\_ drinks per day

Do you smoke or use tobacco? No \_\_\_\_\_ Yes \_\_\_\_\_

What and how much? \_\_\_\_\_

Do you have a bedpartner? No \_\_\_\_\_ Yes \_\_\_\_\_

Does your bedpartner or someone else in your home have any problems that might be interfering with your sleep? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Are there any distractions or annoyances in or around your sleep environment? No \_\_\_\_\_ Yes \_\_\_\_\_

How often do you do the following activities in bed during the average week?

Read in bed	_____ times per week
Watch television in bed	_____ times per week
Eat in bed	_____ times per week
Work in bed	_____ times per week
Argue in bed	_____ times per week
Worry in bed	_____ times per week

Do you have a problem with fatigue even when you are not sleepy? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you been evaluated for sleep problems in the past? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, give the name of physician and place of evaluation: \_\_\_\_\_

### **Medical History:**

Are you in good health? No \_\_\_\_\_ Yes \_\_\_\_\_

Give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Year of your last physical examination \_\_\_\_\_ Doctor's name \_\_\_\_\_

Doctor's address \_\_\_\_\_

Doctor's telephone \_\_\_\_\_ Doctor's specialty \_\_\_\_\_

Was anything found wrong in the last physical examination? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please place a check mark next to any conditions you have had:

_____ Arthritis	_____ Heart attack or stroke	_____ Wear dentures
_____ Asthma or allergies	_____ Heartburn	
_____ Breathing trouble at night	_____ Heart disease/heart failure	
_____ Cancer	_____ Hiatal hernia	
_____ Chronic pain	_____ High blood pressure	
_____ Dental problems	_____ Hyperactivity as a child	
_____ Depression	_____ Kidney problems	
_____ Diabetes	_____ Nose and throat problems	
_____ Drug and alcohol problems	_____ (including nasal congestion)	
_____ Emphysema	_____ Panic attacks	
_____ Epilepsy or seizures	_____ Parkinson's disease	

\_\_\_\_\_ Fibromyalgia  
\_\_\_\_\_ Frequent or morning headaches  
\_\_\_\_\_ Hallucinations or delusions  
\_\_\_\_\_ Head injury or surgery

\_\_\_\_\_ Severe anxiety or nervousness  
\_\_\_\_\_ Sexual problems or decreased interest  
\_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ Thyroid problems

Do you have any medical problems not listed above? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Operations and/or hospitalizations:

Year	Operation/Reason for Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____

Do you take any medication? No \_\_\_\_\_ Yes \_\_\_\_\_

Please give details, including over-the-counter medicines and supplements:

Name	Amount/dose	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any medications or use alcoholic beverages to help with your sleep? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated by a psychiatrist, psychologist, or other mental health profession?

No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please indicate when you were treated and for what type of problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family been diagnosed with sleep apnea or narcolepsy? No \_\_\_\_\_ Yes \_\_\_\_\_

**Sleep Problems / Complaints:**

How long do you or your bedpartner believe you've had a sleep problem? \_\_\_\_\_

How many nights per week do you have a sleep problem? \_\_\_\_\_

Do you have any trouble getting to sleep at night? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you bothered by waking up too early and not being able to get back to sleep? No \_\_\_\_\_ Yes \_\_\_\_\_

If you awaken during the night (after you've fallen asleep), what part(s) of your sleep period is interrupted?  
(Please check all that apply.)

- \_\_\_\_\_ soon after falling asleep
- \_\_\_\_\_ middle of the night
- \_\_\_\_\_ early morning

What time do you usually go to bed? On work nights \_\_\_\_\_ On other nights? \_\_\_\_\_

Does your bedtime vary more than one hour from night to night? No \_\_\_\_\_ Yes \_\_\_\_\_

What time do you usually get up? On work days \_\_\_\_\_ On other days? \_\_\_\_\_

Do you feel that you get too little sleep at night? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you "sleep in" in the morning (longer than one hour past your usual time to get up) whenever possible?  
No \_\_\_\_\_ Yes \_\_\_\_\_

Estimate how many hours of sleep you get:

- A. on an average night \_\_\_\_\_
- B. on a bad night \_\_\_\_\_

How many nights per week do you get:

- A. an average night's sleep \_\_\_\_\_
- B. a bad night's sleep \_\_\_\_\_

How long does it take you to fall asleep?

- A. on an average night \_\_\_\_\_
- B. on a bad night \_\_\_\_\_

How many times do you awaken during the night?

- A. on an average night \_\_\_\_\_
- B. on a bad night \_\_\_\_\_

How long are you awake during the night after initially falling asleep?

- A. on an average night \_\_\_\_\_
- B. on a bad night \_\_\_\_\_

How long are you awake in the morning before finally getting up?

- A. on an average night \_\_\_\_\_
- B. on a bad night \_\_\_\_\_

What do you usually do when you awaken during the night?

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Please rate how often you:

Never      Rarely      Sometimes      Frequently      Constantly

Remember your dreams

\_\_\_\_\_

Have vivid dream-like scenes upon  
awakening or going to sleep  
(dream while awake)

\_\_\_\_\_

	Never	Rarely	Sometimes	Frequently	Constantly
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Become weak when laughing/crying/emotional to the point of collapse, without fainting	_____	_____	_____	_____	_____
Fall asleep involuntarily during the day	_____	_____	_____	_____	_____
Fall asleep during physical effort	_____	_____	_____	_____	_____
Fall asleep when laughing or crying	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Have difficulty awakening in the morning	_____	_____	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____	_____	_____
Take something to keep you awake during the day	_____	_____	_____	_____	_____
Awaken from sleep short of breath	_____	_____	_____	_____	_____
Snore	_____	_____	_____	_____	_____
Snore loudly enough that others complain	_____	_____	_____	_____	_____
Sleep with your mouth open	_____	_____	_____	_____	_____
Awaken with dry mouth	_____	_____	_____	_____	_____
Have breathing problems during the night (observed by self or others)	_____	_____	_____	_____	_____
Suddenly wake up gasping for breath during the night	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching or cough/wheezing	_____	_____	_____	_____	_____
Sweat excessively during the night	_____	_____	_____	_____	_____
Awaken with a headache	_____	_____	_____	_____	_____
Are bothered by pain during the day	_____	_____	_____	_____	_____
Are awakened by pain during the night	_____	_____	_____	_____	_____
	Never	Rarely	Sometimes	Frequently	Constantly

Wake up feeling stiff in the mornings	_____	_____	_____	_____	_____
Wake up with sore or achy muscles	_____	_____	_____	_____	_____
Wake up with pain in the neck, spine, or joints	_____	_____	_____	_____	_____
Notice that parts of your body jerk	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs before sleep	_____	_____	_____	_____	_____
Experience any type of leg pain during the day	_____	_____	_____	_____	_____
Have morning jaw pain	_____	_____	_____	_____	_____
Grind teeth during sleep	_____	_____	_____	_____	_____
Notice your heart pounding or beating irregularly during the night	_____	_____	_____	_____	_____
Feel afraid to go to sleep	_____	_____	_____	_____	_____
Have nightmares	_____	_____	_____	_____	_____
Have thoughts racing through your mind	_____	_____	_____	_____	_____
Feel sad and depressed	_____	_____	_____	_____	_____
Have anxiety (worry about things)	_____	_____	_____	_____	_____
Take something to help you sleep	_____	_____	_____	_____	_____
Wet the bed	_____	_____	_____	_____	_____
Eat during the night	_____	_____	_____	_____	_____

Do you have any unusual or undesirable behavior during sleep of which you or others are aware, such as walking or talking during sleep? No \_\_\_\_\_ Yes \_\_\_\_\_  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Do you sleep better away from home (e.g., in a motel, etc.)? No \_\_\_\_\_ Yes \_\_\_\_\_  
 If yes, why is this? \_\_\_\_\_

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Did you have sleep problems as a child? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe sleep problems: \_\_\_\_\_

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When awakening after an average night of sleep, are you

\_\_\_\_\_ drowsy and wish you were asleep

\_\_\_\_\_ tired but not drowsy

\_\_\_\_\_ awake but not alert

\_\_\_\_\_ fully alert

If you awaken before the expected time, are you

\_\_\_\_\_ upset because you will have difficulty going back to sleep

\_\_\_\_\_ happy to have a chance to get up and start the day early

\_\_\_\_\_ happy that you will have an opportunity to go back to sleep

Describe the positions in which you sleep and/or go to sleep: \_\_\_\_\_

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Describe any comforter which you bring to bed to help you sleep: \_\_\_\_\_

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On the scale below, please estimate the severity of your problem(s):

\_\_\_\_\_ mildly upsetting

\_\_\_\_\_ moderately severe

\_\_\_\_\_ very severe

\_\_\_\_\_ extremely severe

\_\_\_\_\_ totally incapacitating

How strongly do you want help with your problem?

\_\_\_\_\_ very much

\_\_\_\_\_ much

\_\_\_\_\_ moderately

\_\_\_\_\_ slightly

\_\_\_\_\_ could do without it

If there is anything you do to improve your problem, please describe it here:

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What is your personal interpretation of your particular sleep/wake problem?

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Remarks: If there are any other aspects of your sleep problem you feel are important, please describe them here:

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