ATLANTIC SLEEP HEALTH
DIAGNOSTIC ASSOCIATES, LLC

An Affiliate of Atlantic Pulmonary and Critical Care Associates, P.A.

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Patient's Sleep Questionnaire

Name:_____DOB:_____Date:_____

Your answers to the following questions will help us to obtain a better understanding of your sleep problems. Please answer every question to the best of your ability.

Address:_____ City:_____ State/Zip:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

Height:____ Weight:_____ Sex:____ Marital Status:____ Occupation:_____

Referring Physician:_____ Primary Care Physician:_____

How did you hear about us?_____

Has your weight changed? Yes / No Gain / Loss Amount:_____ Time involved:_____

When did your sleep problems begin? _____

Briefly describe your sleep problems:_____
_____
_____

1. Do you have any of the following medical conditions? (circle if yes)
   HIV/AIDS Hepatitis Tuberculosis MRSA

2. Do you have any physical limitations or do you use any handicapped assistive devices? Yes / No
   If yes, please describe: _____

3. Do you have any allergies, including medication allergies? Yes / No
   If yes, please describe: _____

4. Do you have a pacemaker/defibrillator? Yes / No
   If yes, please list date of implant: _____

5. Have you had any other heart related surgery? Yes / No
   If yes, please list reason and year: _____

Name:_____DOB:_____Date:_____

6. Have you ever had a head injury or central nervous system infection? Yes / No
7. Have you ever had a nasal injury? Yes / No
8. Have you had nasal surgery? Yes / No
9. Have you had a tonsillectomy or adenoidectomy? Yes / No
10. Are you a shift worker? Yes / No
11. Do you have trouble falling asleep? Yes / No
12. Do you frequently awaken during the night? Yes / No
13. Do you wake up and not go back to sleep? Yes / No
14. Do you snore? Yes / No
15. Do you toss, turn or kick? Yes / No
16. Does snoring or kicking prevent someone from sleeping in the same bed with you? Yes / No
17. Do you wake up suffocating? Yes / No
18. Have you been told that you stop breathing for any period of time during the night? Yes / No
19. Do you waken with a headache, feeling tired, disoriented? Yes / No
20. How many times do you go to the bathroom during the night? _____
21. Do you fall asleep during inappropriate times, such as during conversations? Yes / No
22. Have you ever fallen asleep while driving a motor vehicle? Yes / No
23. Have you ever had accidents at work related to sleepiness? Yes / No
24. Do you grind your teeth during sleep? Yes / No
25. Do you have a creeping feeling in your legs that is decreased by moving? Yes / No
26. Do you have involuntary leg movement during sleep? Yes / No
27. Do you hallucinate before sleeping? Yes / No
28. Do you ever feel that you cannot move after laying down or just after you awaken? Yes / No
29. Do you ever feel sudden weakness in your limbs when you're laughing or emotional? Yes / No
30. Do you ever find yourself somewhere and not know how you got there? Yes / No