ATLANTIC SLEEP HEALTH
DIAGNOSTIC ASSOCIATES, LLC

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

Salaam T. Alobeidy, M.D., F.C.C.P., D.A.B.S.M.
Nancy C. Higgins, M.D., F.C.C.P, D.A.B.S.M.
Nadia Sadik, M.D., F.A.C.P., F.C.C.P.,
ABIM Board Certified, Sleep Medicine

110 E. Jimmie Leeds Road
Galloway, NJ 08205-9508
TEL: (609) 748-7900
FAX: (609) 748-7922

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.

Sex: Male / Female Height:_____ Weight:_____

Has your weight changed? Yes / No
If yes, please describe: Gain / Loss Amount:_____ Time involved:_____

1. Do you have any of the following medical conditions? Yes / No
   If yes, please circle: 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: _____
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 a tonsillectomy or adenoidectomy? Yes / No
9. Have you ever been diagnosed with a Sleep Disorder? Yes / No
   If yes, please list: _____
10. Do you currently use PAP therapy or a Mandibular Advancement Device? Yes / No
    If yes, please describe: _____

Name:_____DOB:_____Date:_____

11. Do you work a swing shift and/or overnight shift? Yes / No

12. Do you normally sleep on your back? Yes / No

13. How many times do you go to the bathroom during the night? _____

14. Please mark all symptoms that you experience at night:

__trouble falling asleep	__trouble staying asleep	__snoring
__involuntary leg jerking	__toss, turn, kick during sleep	__teeth grinding
__wake up suffocating	__stop breathing while asleep	__hallucinations
__feeling paralyzed	__sleep walking	__sleep talking

15. Please mark all symptoms that you experience during the day:

__wake up tired	__morning headaches	__feeling forgetful
__falling asleep during the day	__falling asleep while driving	__feeling disoriented
__accidents due to sleepiness	__creeping feeling in legs	__trouble focusing
__sudden weakness when emotional		

16. I began experiencing these symptoms about ___ months/years ago.