Workstation:__________ Site:__________ Date:_________

Occupation:________________________________Shift Worker: Yes or No

Referring Physician:________________________Family Physician (PCP):____________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

☐ Trouble sleeping
☐ Being sleepy all day
☐ Snoring
☐ Unwanted behaviors during sleep, explain____________________________________

☐ Other, explain____

Sleep Pattern

	Work Days	Off Days
Typical bedtime:	________a.m./p.m.	__________a.m./p.m.
Typical time you get out of bed:	________a.m./p.m.	__________a.m./p.m.

Please check all of the following statements that are true about your sleep.

Sleep Habits

☐ I usually watch TV or read in bed prior to sleep.
☐ I typically wake up from sleep to go to the bathroom.
☐ I have trouble falling asleep.
☐ I often wake up during the night.
☐ I have nightmares as an adult.
☐ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.
☐ I sweat a great deal during sleep.
☐ I cannot sleep on my back.

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Sleep Position

- ☐ Back
- ☐ Side
- ☐ Stomach

Breathing

- ☐ I have been told that I stop breathing while I sleep.
- ☐ I wake up at night choking, smothering or gasping for air.
- ☐ I have been told that I snore.
- ☐ I have been told that I snore only when sleeping on my back.

Restlessness

- ☐ I have uncomfortable feelings in my legs and/or arms when I lie down at night.
- ☐ I have to move my legs or walk to relieve the uncomfortable feelings in my legs.
- ☐ I have been told that I kick or jerk my legs and/or arms during sleep.
- ☐ I grind my teeth in my sleep.

Daytime Sleepiness

- ☐ I have trouble doing my job because of sleepiness or fatigue.
- ☐ I often have to let someone else drive the car because I am too sleepy to drive.
- ☐ I have fallen asleep while driving.
- ☐ I have had auto accidents as a result of falling asleep while driving.
- ☐ I have had sudden muscle weakness in response to emotions such as laughter or anger.
- ☐ I feel unable to move while falling asleep or when waking up.
- ☐ I have had hallucinations or dreamlike images when falling asleep or waking up.

Habits

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

I drink caffeinated beverages during the day: _____cups/bottles/cans per day.

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

- ☐ My job requires driving a vehicle.
- ☐ I work with dangerous equipment or substances.
- ☐ I am a permanent or long-term, third-shift worker.
- ☐ I am currently a student.

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Medical History

Vital Statistics

What is your: Height? ____feet ____inches. Weight? ____pounds. Neck Size: ____.
Did you have a weight change over the last 5 years? Gain _____lbs. Lost ________lbs.

Allergies: ____

____

____

Past Medical History

- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ Diabetes (insulin dependent)
- ☐ Stomach or colon problems
- ☐ Lung problems/COPD/asthma
- ☐ Reflux
- ☐ Fibromyalgia
- ☐ Seizures
- ☐ Pacemaker
- ☐ Depression or severe anxiety
- ☐ Hearing impairment
- ☐ HIV
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Stroke
- ☐ Blackouts
- ☐ Irregular heartbeat
- ☐ Defibrillator

List other medical problems

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Surgeries

- ☐ Tonsillectomy
- ☐ Weight loss surgery
- ☐ Corrective surgery for sleep apnea (laser or UPPP)

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Medication List

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Patient Signature:______________________________ Printed Name:________________________ Date:________ Time:________

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