



SLEEP QUESTIONNAIRE

Appt Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____ Sex: _____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

Please select all boxes that correspond to symptoms you experience.

Primary Sleep Concerns

Please describe the reason for your visit today: _____

How long have you had the above issue(s)? _____

Prior Sleep Disorder Diagnoses/Studies

Please list any **sleep disorders** you have previously been diagnosed with. Include dates and names of provider(s)/facility who did the diagnosis.

Prior Sleep Studies (please indicate Type of Sleep Study, Facility/Provider, and Date (MM/YY) of study)

Current therapy (if applicable): CPAP Bi-level (Settings: _____) **Dental device use?** Yes No

Sleep Pattern

Typical bedtime: Weekdays: _____ Weekends: _____

How long does it take to fall asleep? _____ hrs _____ mins

Wake-up time: Weekdays: _____ Weekends: _____

Approximately how many hours do you sleep per night? _____ hrs

Number of Awakenings per night: _____ Time taken to fall back asleep: _____ mins

Sleep Apnea Symptoms

- Snoring Woken up by my own snoring Others have told me that I stop breathing while I'm asleep
- Night sweats Wake up gasping/choking Waking up to urinate Teeth grinding during the night
- Dry mouth in the morning Morning headaches I still feel tired in the morning Jaw pain in the morning

Daytime Symptoms

- Excessive daytime drowsiness Brain Fog Difficulty Concentrating Uncontrollable sleep urges
- Naps (___ per day) Fallen asleep while driving Poor school/work performance due to sleepiness

