Sleep Medicine of DFW

ADULT SLEEP QUESTIONNAIRE

PLEASE FILL OUT AND EMAIL IT TO: SleepMedicine@dfwmpc.com

Name: Age/Sex: Date of Birth:
BMI: Neck Circumference: Weight: Height:
Referring Physician: Reason For referral:

Sleep Habits

Check the box for each problem you **CURRENTLY HAVE**

☐	**Snoring**	☐	**Sweating a lot at Night**
☐	**Frequent Awakenings at Night**	☐	**Waking up with Heartburn or Reflux**
☐	**Choking for Breath at Night**	☐	**Waking Up to Urinate**
☐	**Gasping During Sleep**	☐	**Nightmares**
☐	**Witnessed Apnea (Been told that you stop breathing)**	☐	**Morning Headaches**
☐	**Unrefreshing Sleep**	☐	**Morning Dry Mouth**
☐	**Crawling Feeling in Legs when Trying to Sleep**	☐	**Sleepwalking**
☐	**Leg-kicking During Sleep**	☐	**Sleep Terrors**
☐	**Leg Cramps in Sleep**	☐	**Bedwetting**
☐	**Trouble Falling Asleep or Staying Asleep at Night**	☐	**Acting out Dreams**
☐	**Fear of Being Unable to Sleep**	☐	**Feeling Paralyzed when Falling Asleep or Waking Up**
☐	**Inability to Fall Back Asleep After Awakening at Night**	☐	**I Use Sleeping Pills to Help me Sleep**
☐	**Waking too Early in the Morning**	☐	**I Use Alcohol to Help Me Sleep**
☐	**Sleep Talking**	☐	**Pain Interfering with Sleep: Where is the Pain?**

Daytime Symptoms & Complaints

Do you nap? If yes: How often do you nap? Times per week
How long are your naps? Minutes

Sleep History

Please provide the following information:
Your Bedtime on WEEKDAYS AM/PM Time you get up on WEEKDAYS AM/PM
Your bedtime on WEEKENDS AM/PM Time you get up on WEEKENDS AM/PM

Have you ever had a sleep study before?
If yes: Where and when did you have the study?

Are you a shift worker? If yes: What kind of shift do you work?

Do you use a CPAP or BIPAP machine at home? What are your current pressure settings? cmH2O
Please provide the name of your Durable Medical Equipment Company (DME), if applicable

Are you on home oxygen? What liter flow of oxygen? L/Min
Do you use the oxygen for sleep only?

List any current and previous sleep medications you have tried