Infinity Sleep Solutions

"A Better Night's Sleep"

Patient Name: ____ DOB: ____/_____/_____

Patient Sleep Questionnaire

Age: _______ Sex: M / F Height: ________ Weight: __________ Phone Number: _________________

Home Address: ____

Occupation: _____________________Usual work hours/days_____________________________________

Referring Physician Name: ____

Emergency Contact: ______________________________Relationship:_____________________________

Phone Number (Must be different than above listed number):___________________________________

What is your main sleep complaint?

____

____

What is the reason your physician has ordered a sleep study for you?

____

____

What is your normal bed time? _____ AM / PM What is your normal wake time? _________ AM / PM

On average, how long do you feel it takes you to fall asleep? ___________

On average, how many hours of sleep do you feel you achieve at night? ___________

What is your predominant position for sleeping? Back / Stomach / Side / Sitting Up

Please check if you have had any of the following problems:

- ☐ Asthma, Chronic lung disease (COPD, Emphysema) ☐ Thyroid Disease ☐ Diabetes
- ☐ Heart Disease /Atrial Fibrillation ☐ Depression ☐ GERD
- ☐ Anxiety, Panic Attacks or Claustrophobia ☐ Stroke ☐ Seizure disorder
- ☐ Hypertension (high blood pressure) ☐ Chronic nasal / Sinus problems
- ☐ Other nose or throat surgery / Tonsillectomy

Please list all medications you currently take include prescription, Non-prescription and any sleeping agents. (Please attach a list if needed)

____

____

Do you have any allergies (such as tape)? If yes, please describe: ________________________________

Use the following scale to choose the most appropriate number for each situation.

Situation or Activity	**Chance of Dozing**
0 = would never doze 1 = slight change 2 = moderate chance 3 = high chance	(0) (1) (2) (3)
Sitting and watching TV	☐ ☐ ☐ ☐
Sitting and Reading	☐ ☐ ☐ ☐
Sitting inactive in a public place (theatre/meeting)	☐ ☐ ☐ ☐
As a passenger in a car for an hour without a break	☐ ☐ ☐ ☐
Lying down to rest in the afternoon when circumstances permit	☐ ☐ ☐ ☐
Sitting and talking to someone	☐ ☐ ☐ ☐
Sitting quietly after a lunch with no alcohol	☐ ☐ ☐ ☐
In a car, while stopped for a few minutes in traffic	☐ ☐ ☐ ☐
Total:	

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Please circle Y for Yes or N for No

Y/N Have ever had a sleep study previously?
Y/N Have you ever been diagnosed with a sleep disorder?
Y/N Have you ever had surgery for a sleep problem or snoring?
Y/N Do you use oxygen when you sleep? If yes, how much? LPM: __________
Y/N Has anyone in your family ever been diagnosed with a sleep problem? If yes, please describe:
____
____

Y/N Do you use medication to help you sleep?
Y/N Do you drink alcoholic beverages? If yes, how many drinks per day? _________________________
Y/N Do you regularly drink caffeinated beverages? If yes, how many cups per day? ________________
Y/N Do you use Tobacco?
If yes, what type? Cigarettes / Cigars / Chewing. How many/much per day? __________________
Y/N Do you have trouble relaxing and feeling ready to go to sleep?
Y/N Do you wake up too early and have trouble falling back to sleep?
Y/N Do you experience a creeping-crawling or tingling sensation in your legs
Y/N Do you ever hear, see or feel things that may not be real as you are falling asleep?
Y/N Have you ever awakened feeling like you are awake but cannot move momentarily?
Y/N Have you ever had the sensation of weakness in reaction to an emotional response?
Y/N Do you take daily naps? If yes, for how long? _______
Y/N Do you feel tired when you wake up?
Y/N Are you sleepy at any time during the day?
Y/N Have you ever had accidents or near accidents due to sleepiness
Y/N Do you have a history of sleep walking?
Y/N Do you talk and/or eat in your sleep?
Y/N Do you grind your teeth in your sleep?
Y/N Does your partner complain about your leg movements at night during sleep?
Y/N Do you have nightmares?
Y/N Have you ever been told that you are acting out your dreams?
Y/N As an adult, do you have a history of bed wetting?
Y/N Have you ever awakened confused or disoriented?
Y/N Do you snore? Has anyone told you that you stop breathing in your sleep?
Y/N Do you ever awake with gasping breaths or racing heart beat?
Y/N Do you wake in the morning with a headache?
Y/N Do you wake in the morning with dry mouth?
Y/N Do any of the following affect your ability to sleep? **Check all that apply**
☐ Pain/discomfort ☐ Sweating ☐ Headaches ☐ Leg Discomfort ☐ Heartburn
☐ Cough ☐ Shortness of Breath ☐ Frequent Urination ☐ Anxiety, stress/racing thoughts
☐ Disruptive sleep environments (i.e. partner/ noise)
Y/N Do you perform the following in bed? **Check all that apply**.
☐ Argue ☐ Check the clock ☐ TV ☐ Worry ☐ Eat ☐ Read/Write ☐ use computer