Sioux Falls Sleep Center

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Sleep Questionnaire

Name ___________________________________ Date _____________________________

What time do you go to bed? ____________
On days off: ____________

How long before you fall asleep? ____________

How many times do you wake up during the night? ____________

How many times do you go to the bathroom during the night? ____________

What time do you get out of bed in the morning? ____________
On days off? ____________

Do you use an alarm clock? ☐ Yes ☐ No

What time do you have to get to work? ____________

Any shift work? ☐ Yes ☐ No

Do you nap? ☐ Yes ☐ No
If yes how long? ____________

Do you doze off? ☐ Yes ☐ No
If yes what time of day? ____________

Sleep better away from home? ☐ Yes ☐ No
If yes explain? ____________

Do you exercise? ☐ Yes ☐ No
If yes what kind? ____________
What time of day? ____________

Do you snore? ☐ Yes ☐ No
Do you stop breathing at night? ☐ Yes ☐ No
Any nasal congestion? ☐ Yes ☐ No
Ever broke your nose? ☐ Yes ☐ No
Runny nose? ☐ Yes ☐ No

Are you Claustrophobic? ☐ Yes ☐ No
Are you an anxious person? ☐ Yes ☐ No
Do you worry to much? ☐ Yes ☐ No
If yes about what? ____________
____

Do you grind your teeth? ☐ Yes ☐ No
Sleep walking? ☐ Yes ☐ No
Sleep talking? ☐ Yes ☐ No
Do you act out your dreams? ☐ Yes ☐ No
Frequent dreams/nightmares? ☐ Yes ☐ No

Any restlessness of the legs? ☐ Yes ☐ No
If yes is it worse in the evening? ____________
Is it better with movement? ☐ Yes ☐ No
Does it keep you up at night? ☐ Yes ☐ No

Ever woke up feeling paralyzed or unable to move? ☐ Yes ☐ No

Do you feel weak in the legs during the day, with emotions or laughter? ☐ Yes ☐ No

Ever had your knees buckle with emotions or laughter? ☐ Yes ☐ No

Do you have very vivid dreams that you cannot discern from reality? ☐ Yes ☐ No

Do you have seizures with sleep? ☐ Yes ☐ No

What relaxes you? ____________

Is your bedroom noisy? ☐ Yes ☐ No
Is your bed comfortable? ☐ Yes ☐ No
Anyone shares your bed? ☐ Yes ☐ No
Does she/he disrupt your sleep? ☐ Yes ☐ No