HealthCare

☐ University of Kentucky Hospital A.B. Chandler Medical Center
☐ UK HealthCare Good Samaritan Hospital
☐ UK HealthCare Ambulatory Services
☐ UK Dental and Oral Heatlh Clinics

SLEEP DISORDERS CENTER ADULT PATIENT QUESTIONNAIRE

(Patient Label Here)

Thank you for helping us to take better care of you! Please complete the following:

Name:_____ Date of Birth: _____

Patient's Preferred Language: _____

Home Address: _____

Home Phone: _____ Other Phone: _____

Height: _____ Weight: _____ Referring MD: _____

Other MD's you would like us to communicate with: _____

Please describe your sleep problem: _____

_____

How long ago did this problem begin? _____

Please describe any previous evaluation or treatment for this problem (sleep study, CPAP, etc) _____

_____

Do you snore?	☐ YES	☐ NO	
Do you stop breathing while you sleep?	☐ YES	☐ NO	
Have you ever gasped or choked awake from sleep?	☐ YES	☐ NO	
Do you feel rested when you wake up in the morning?	☐ YES	☐ NO	
Do you feel sleepy during the day?	☐ YES	☐ NO	
Have you gained weight in the last year?	☐ YES	☐ NO	If yes, how much? _____
Do you often have trouble falling asleep?	☐ YES	☐ NO	
Do you wake up frequently during the night?	☐ YES	☐ NO	
Do you routinely experience an abnormal sensation in your legs which prevents you from falling asleep, also known as "restless legs?"	☐ YES	☐ NO	
Have you ever experienced sudden body weakness brought on by laughter, surprise, or fear?	☐ YES	☐ NO	
Have you ever experienced seeing or hearing things that were not real when you were going to sleep or just waking up?	☐ YES	☐ NO	
Have you ever uncontrollably fallen asleep at an inappropriate time or place when you were trying hard to stay awake?	☐ YES	☐ NO	

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Have you ever woken up from sleep and your mind is awake but your body will not move? ☐ YES ☐ NO

What is your occupation? _____

Do you do shift work? ☐ YES ☐ NO If yes, please describe your schedule: _____

List your sleeping hours WORK DAYS: Go to bed _____a.m. /p.m. Get up _____ a.m. /p.m.

List your sleeping hours NON WORK DAYS: Go to bed_____ a.m. /p.m. Get up _____a.m./pm

Do you take any medications or herbal remedies to help you sleep? ☐ YES ☐ NO If yes, what are they and what time do you take them? _____

Do you take any medications to help you stay awake/alert? ☐ YES ☐ NO If yes, what are they and what time do you take them? _____

How long does it usually take you to fall asleep after turning out the lights? _____ Minutes

Do you watch TV, read or use your phone in bed? ☐ YES ☐ NO

On average, how many times do you wake up during the night? _____

On average, how many times do you get out of the bed at night? _____

If you get up at night, what is the reason that wakes you up or gets you up? _____

How long does it take you to fall back asleep? _____

If you are unable to fall back asleep what do you do? _____

Do you wake up too early in the morning, unable to return to sleep? ☐ YES ☐ NO

How do you ordinarily awaken? ☐ Spontaneously ☐ Alarm clock ☐ Other _____

Do you nap? ☐ YES ☐ NO If yes, how many times a week? _____ If so, for how long? _____

If yes, do you find naps refreshing? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If yes, how many days of the week do you drink? _____

If you drink alcohol, on average how many alcoholic beverages do you drink on weekdays? _____ drinks/day

If you drink alcohol, on average how many alcoholic beverages do you drink on weekends? _____ drinks/day

Do you smoke? ☐ YES ☐ NO If yes, how many cigarettes, pipes, or cigars/day? _____

For each of the following, please indicate the average number that you drink each day and how late in the day you drink them:

Coffee _____ cups / day Latest drink _____

Tea _____ cups / day Latest drink _____

Caffeinated soft drinks (Pepsi, Coca Cola, and Mountain Dew) _____/ day Latest drink _____

Energy drinks _____/ day Latest drink _____