

## Sleep Questionnaire

Date: \_\_\_\_\_

Please complete this questionnaire as this information will be very helpful for assessment of your sleep disorder.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck: \_\_\_\_\_ BMI: \_\_\_\_\_

**Work History:** (place of work, job description, shifts worked – including time of shifts)

\_\_\_\_\_

What is the main problem that you would like the sleep lab to address? \_\_\_\_\_

\_\_\_\_\_

Have you undergone previous sleep study testing at any sleep facility? YES / NO

If YES, where? When? \_\_\_\_\_

**Diagnosed Sleep Apnea:** YES / NO If NO, advance to “Sleep History”

If YES, on CPAP? YES / NO Dental Appliance? YES / NO

Worn \_\_\_\_\_ hours per night; number of days per week used? \_\_\_\_\_

Snoring with treatment CPAP / Dental Appliance? YES / NO

Apnea with treatment CPAP / Dental Appliance? YES / NO

Tiredness with treatment CPAP / Dental Appliance? YES / NO

### Sleep History:

Snoring YES / NO

Breathing Pausing/stop YES / NO

Gasp for breath YES / NO

Cough/choke YES / NO

Jerking/jumping of legs YES / NO

Night sweats YES / NO

Usual bedtime: \_\_\_\_\_ How long does it take for you to fall asleep? \_\_\_\_\_

**Malvern Sleep Clinic**  
**1371 Neilson Road, Suite 306**  
**Scarborough, ON, M1B 4Z8**  
**Phone: 416-282-9119 Fax: 416-282-4141**

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How many awakenings do you experience in a typical night? \_\_\_\_\_

What do you think wakes you up? \_\_\_\_\_ Usual rise time? \_\_\_\_\_

Do you feel refreshed upon awakening? \_\_\_\_\_ Do you have headaches upon awakening? \_\_\_\_\_

**Tiredness During the Day:** YES / NO If YES, what level? Mild/Moderate/Severe/Exhausted

Intentional napping YES / NO If YES, times per week? Length? \_\_\_\_\_

**Alertness While Driving:** Do you drive? YES / NO

If YES, do you experience any drowsiness while driving? YES / NO

**Family History:** Asthma YES / NO Bronchitis/Emphysema/COPD YES / NO

Other problems? \_\_\_\_\_

**Nasal History:** (sinusitis/allergies/deviated nasal septum/congestion/previous surgeries, etc.)

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**Dental History:** (crowns/bridges/dentures/problems with bite/TMJ/dental surgeries, etc.)

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Do you grind your teeth at night? \_\_\_\_\_ Do you have all your teeth? \_\_\_\_\_

Tonsils? IN / OUT Dry Mouth YES / NO

**Mental Health:** Suffering from depression or other psychiatric disorders recently? \_\_\_\_\_

Please list any **Previous Illnesses and/or Operations** you have had: \_\_\_\_\_

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Please list all **Medications** you are currently taking: \_\_\_\_\_

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List any **Medication Allergies:** \_\_\_\_\_

Has your weight changed in the last 3 years? YES / NO

If YES, please describe: \_\_\_\_\_

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Do you smoke?      YES / NO      If YES, how many packs/day? Since what age? \_\_\_\_\_

Do you partake in any recreational drugs (including Marijuana)?      YES / NO

Do you drink alcohol?      YES / NO

If YES, how many glasses or wine/beer/hard liquor per day/week? \_\_\_\_\_

How much of the following do you take each day?

Coffee \_\_\_\_\_ Cola/Soda \_\_\_\_\_ Tea \_\_\_\_\_

Cocoa \_\_\_\_\_ Chocolate \_\_\_\_\_

**Please answer the following questions as completely as possible.**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would've affected you.

**Using the following scale, circle the *most appropriate number* for each situation.**

**0 = would *never* doze**

**1 = *slight* chance of dozing**

**2 = *moderate* chance of dozing**

**3 = *high* chance of dozing**

<b>Situation</b>	<b>Chance of Dozing</b>			
Sitting and reading	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Watching TV	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Sitting, inactive in a public place (theatre, meeting, etc.)	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
As a passenger in a car for an hour without a break	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Lying down to rest in the afternoon	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Sitting and talking to someone	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Sitting quietly after lunch without alcohol	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
In a car, while stopped for a few minutes in the traffic	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>