Wake Sleep
Sleep Disorders Center
Accredited by the American Academy of Sleep Medicine
Wake Sleep is the Sleep Lab with a Sleep Clinic.
Diagnose, Treat and Educate

3100 Duraleigh Road Suite 302,
Raleigh, NC 27612
Phone: 919-645-9280
Fax 919-208-2149

Patient Sleep Questionnaire

Name:______________________________________ Date:______________

Height:_____ Weight: ________ DOB:____________

Reason for sleep evaluation____

Referring Physician ____

How long have you had this problem? __________________________________

Mark any of the occurrences that either you or someone else has observed of you:

☐ Snoring	☐ Acting Out Dreams	☐ Creeping/Crawling Feeling In Legs
☐ Leg Jerks	☐ Nighttime Wheezing	☐ Feel The Need To Move Your Legs
☐ Restless Sleep	☐ Sleep Walking	☐ Vivid Dreams/Nightmares
☐ Talking In Sleep	☐ Morning Headaches	☐ Pain That Interferes With Sleep
☐ Teeth Grinding	☐ Wake Up Gasping For Air	☐ Awaken With Dry Mouth
☐ Sleep Disturbance	☐ unable to stop thinking	☐ Stop Breathing While Sleeping

Estimate your risk of falling asleep in the following situations, using this scale:

0 = No chance 1= Slight chance 2= Moderate chance 3= High chance

Sitting and reading :	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon :	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV :	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car, for an hour, with no break :	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive, in public (Theater, Meetings, Etc,) :	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch, without Alcohol:	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone:	☐ 0	☐ 1	☐ 2	☐ 3
In a car, stopped in traffic, for a few minutes:	☐ 0	☐ 1	☐ 2	☐ 3

Total_______

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Name: ________________________________

Please list all your medications that you are currently taken:

Past or Current Medical Problems: ____

____
____
____

Do you have a history of: (Please check all boxes that apply)

☐ Stroke or TIA	☐ Seizures/ Neurological Diseases	☐ High Blood Pressure
☐ Diabetes	☐ Drug or Alcohol Addiction	☐ Kidney Disease
☐ Heart Disease	☐ Deviated Nasal Septum	☐ Lung Disease
☐ Thyroid Issues	☐ Anxiety	☐ Depression

Is there anyone in your family with the following conditions?

☐ Seizures	☐ Dementia	☐ Excessive Sleepiness	☐ Parkinson's Disease
☐ Narcolepsy	☐ Insomnia	☐ Sleep Apnea	☐ None

If you marked any of the above conditions please list relationship to effected person:
____

Is your Nighttime sleep refreshing? ☐ Yes ☐ No

Are you tied/sleepy or fatigued during the day? ☐ Yes ☐ No

If you snore, what sleeping positions do you snore in? ☐ Back ☐ Side ☐ Stomach

Does your snoring disturb others? ☐ Yes ☐ No

What positions do you sleep in: ☐ Back ☐ Side ☐ Stomach?

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Name: ________________________________

Mark any of the following that you do while you are in bed:
☐ Read ☐ Eat ☐ Watch TV ☐ Do work activities ☐ Sleep with the TV on
Name:

How many times do you wake to use the restroom? _________________________________

How long does it take you to fall back to sleep? _________________________________

If you have difficulty falling asleep, what do you do? _____________________________

Do you take naps? ☐ Yes ☐ No
If yes, how long are they? ____

Do you dream during the naps? ☐ Yes ☐ No

Are the naps refreshing? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No
If yes, what time of day do you exercise? ______________________________________

Have you had your tonsils removed? ☐ Yes ☐ No If so, at what age?_________________

Does your work schedule involve shift work? ______________________________________

If so, what shift?____

Do you smoke? ☐ Yes ☐ No
If so, for how many years and how much? ______________________________________

Do you drink Alcohol? ☐ Yes ☐ No
If so, how many drinks per week?____

Do you drink coffee, caffeinated soda, or tea? ☐ Yes ☐ No
If so, how many cups per day? ____

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