Lake Norman Neurology
Piedmont HealthCare

Sleep Study Questionare

Name:_____ Sex: Male_____ Female_____

Address:_____

City/State/Zip_____

Telephone: Daytime ( )_____ Evening ( )_____

Date of Birth:_____ Age:_____ Height:_____

Please list your body weight:

A. Now _____lbs.
B. 20 yrs old _____lbs
C. Heaviest _____lbs.

Occupation:_____

Sleep History:
Please describe your sleep problem that led your physician to order this study:

_____

_____

How long have you had this problem? _____

Has anyone told you that you snore loudly? Yes_____ No_____

If yes, has your snoring caused people to refuse
To sleep in the same room? Yes_____ No_____

Has anyone noticed you stop breathing in your sleep? Yes_____ No_____
How frequently? _____

Please indicate if you have noticed, or someone has told you that you:

A. Suddenly wake up gasping for breath Yes____ No_____
B. Wake up with a morning headache Yes____ No_____
C. Snort yourself awake Yes____ No_____
D. Notice your legs jerking or twitching during the night Yes____ No_____
E. Are you unable to move when falling asleep or
Immediately upon waking Yes____ No_____

F. Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, Angry or in other emotional situations. Yes____ No____
G. Wake up confused and wander during the night Yes____ No____

Daytime Fuctioning:

1. Do you have a problem with severe sleepiness (feeling very sleep or struggling to stay awake) During the daytime? Yes____ No____
2. Do you often have a problem with your performace at work because of sleepiness? Yes____ No____
3. Have you ever had a car accident because of sleepiness, not due to drugs or alcohol? Yes____ No____
4. Have you ever had a near car accident? Yes____ No____
   If yes how many times? _____
5. Do you fall asleep without meaning to during the day? Yes____ No____
6. At what time of day do you feel most fatigued?sleep?_____

Sleep Habits:

1. Estimate how many hours of sleep you get? Average night:_____ Bad night:_____
2. What is your normal bedtime? _____ What time do you get out of bed in the morning_____
3. How many naps do you take during the week?_____ How long are your naps?_____
4. How long does it take you to fall asleep? Average night:_____ Bad night:_____
5. How many nights a week do you lie in bed for at least 30 minutes either trying to fall alseep or trying to return to sleep?_____.
6. How many times do you wake up during the night? Average night_____ Bad night_____
7. Does your job require that you change shifts? Yes____ No____
8. How much of the following do you consume during the average day?
   a. Alcohol _____
   b. Coffee (with caffeine) _____
   c. Tea (with caffeine) _____
   d. Soft drinks(with caffeine) _____
   e. Cigarettes _____
   f. Other topacco products _____

Medical History:
Please check if you have ever had any of the following conditions:

____Asthma/Bronchitis
____Chronic pain
____Congestive Heart Failure
____Coronary Artery Disease
____Depression
____Diabetes
____Emphysema
____Epilepsy or seizures
____Frequent Headaches
____High Blood Pressure
____Nasal Obstruction
____Panic or Anxiety Attacks
____Problems with Alcohol or Drugs
____Sexual Function Problems
____Stroke
____Ulcer/Heartburn

Please list all medications you are currently taking, name, dosage, and how you take them (mouth,injection,patch, etc..)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other information you feel is imporant:

_____

_____

_____

_____

Patient's signature:_____ Date:_____
(or Parent/Guardian's signature)