ENTERPRISE
SLEEP & DIAGNOSTICS

Sleep History Questionnaire

Patient's Name Date

Please list of your "sleep related" symptoms:

SYMPTOM	HOW LONG	YES	NO
Do you Snore?			
Is your snoring interrupted by periods of silence, pauses in breathing?			
Has anyone ever witnessed you stop breathing?			
Do you sometimes awaken as if choking?			
Do you fall asleep during the daytime?			
Do you fall asleep during physical exertion?			
Do you fall asleep when laughing or crying?			
Do you fall asleep while driving?			
Do you fall asleep during work or school?			
Do you sweat excessively during sleep?			
Have you noticed your heart pounding or beating irregularly during the night or upon awakening?			
Do you walk in your sleep?			
Do you kick or thrash your arms during your sleep?			
Do you have any type of leg discomfort during the night?			
Are you afraid to go to sleep?			
Do you ever awake by jerking or as if startled?			
Do you remember your dreams?			
Do you have nightmares?			

Please list any additional "sleep related" symptoms you are experiencing: _____

_____

Please check all that apply:

☐ Restless Sleep ☐ Memory Loss ☐ Irritability ☐ Depression ☐ Sexual Dysfunction

How would you rate your sleep complaints: ☐ Mild ☐ Moderate ☐ Severe

Do you have any family members that have sleep related problems? If so, please provide relationship and disorder: _____

Have you ever been tested or treated for a sleep disorder? If so, please provide your best recollection of where and when:

_____