Niagara Neurology and Sleep Medicine PLLC

New sleep patient questionnaire

Name: _____ Referring Doctor:_____

Reason for today's sleep evaluation: _____

Have you done sleep studies in previous years? Yes / No If so when/where:_____

Check Any that apply (even if they occur only on occassion)

_____ snoring

_____ you wake up gasping for air

_____ feel sleepy in the daytime

_____ restless legs

_____ wake up with heart racing/palpitations

_____ wake up feeling sweaty

_____ get up to urinate at night (how many times per night ____?)

_____ wake up with headaches

_____ others have observed pauses in your breathing at night

_____ sleep walking

_____ take naps (how many days per week _____, how long are your naps_____)?

Please fill in the blanks or circle

(You may put a range if that's easier)

I go to bed at: _____ I rise from bed at: _____ I wake up _____ times per night

I live with: _____

Occupation: _____

Do you require paperwork for driving clearance? Yes / No

Do you work shift work? Yes / No

Do you have a CDL (commercial drivers license) ? Yes / No

I am a: nonsmoker / smoker / former smoker
(Former smokers: how many years ago did you quit____, how long did you smoke for____)?

I drink:_____ alcoholic beverages per week

I drink: _____ caffeinated beverages per **day**

Do you have any family members with a history of sleep apnea? Yes / No (Who_____)?