SLEEP MANATEE – Sleep Disorders Questionnaire

Florida Sleep Specialists

Name: _____

Date: _____

1. **Please describe you sleep problem. Be as specific as possible.**
   (For example, *"My bed partner can't sleep because of my snoring" ; " I sometimes fall asleep unintentionally" ; " My bed partner says I stop breathing in my sleep, and it worries him/her" ; "I have trouble getting to sleep at night"; " I'm sleepy most of the time"; " I awaken too many times at night"; "Recently, my sleep hasn't been as refreshing as it once was"; "My bed partner says my legs jerk all through the night"; " I often awaken with heartburn or choking on stomach acid";* etc.)

_____
_____
_____
_____
_____
_____

2. When did your sleep problems begin? _____
3. What time do you usually turn the lights off to go to bed? _____
4. What time do you usually awaken for the day? _____
5. How long does it typically take you to fall asleep each night after the lights are turned off? _____
6. How many times do you awaken during a typical night? _____
7. How many minutes are you typically awake during these awakenings? _____
8. List the reasons that typically cause you to wake up during the night:
   _____
   _____
9. When you awaken in the morning, do you feel refreshed? ☐ YES ☐ NO
   If NO, describe how you feel: _____
10. Do you feel you are sleepier during the day that you should be? ☐ YES ☐ NO
    If YES, at what age did you begin to experience excessive sleepiness? _____
11. Do you sometimes doze or fall asleep when you don't intend to? ☐ YES ☐ NO
12. Do you sometimes experience dreams just as you are falling asleep? ☐ YES ☐ NO
13. When you are falling asleep, do you ever see vivid, life-like images? ☐ YES ☐ NO
14. Have you ever experienced sudden **muscle weakness** (not dizziness, not fainting) associated with an emotional state (for example: laughing, anger, fear) that made it difficult to stand or difficult to maintain control of your head or arms or hands? ☐ YES ☐ NO
15. Have you ever experienced an occasion during which you awoke fully, but found it impossible to move for a minute or so? ☐ YES ☐ NO
    If YES, how often does this happen? _____
16. Have you ever felt paralyzed as you were falling asleep? ☐ YES ☐ NO
    If YES, how often does this happen? _____

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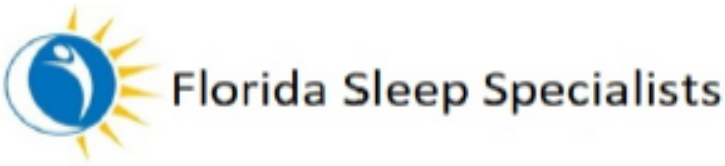

17. Do you ever awaken with headaches that seem to fade away after a few minutes or an hour or so? YES ☐ NO ☐

    If YES, how often do these occur?_____

18. Do you sweat in your sleep even when the room is cool? ☐ YES ☐ NO

19. Do you ever experience a strong sensation of discomfort in your legs when you relax or when you lie down to sleep? YES ☐ NO ☐

    If YES, describe this sensation: (Examples: cramps, a restless sensation requiring movement, ect.)

    _____

    _____

20. Have you been told that you kick or move your legs repeatedly during you sleep? YES ☐ NO ☐

    If YES, how often do you do this? (e.g. every night, once a week)

    _____

    _____

21. Do you or have you ever sleepwalked, or awakened out of your bed with no clear recollection of the preceding events? ☐ YES ☐ NO

    If YES, describe the specific events:

    _____

    _____

22. Do you physically act out you dreams during your sleep? ☐ YES ☐ NO
23. Have you ever damaged property or harmed you bed partner or others during your sleep? ☐ YES ☐ NO

    If YES, please describe these specific events and how often do these events occur:_____

    _____

    _____

24. Do you currently have seizures (epilepsy) or have you ever been treated for seizures in the past? YES ☐ NO ☐
25. Have you ever fallen asleep while driving or had an automobile accident related to sleepiness? YES ☐ NO ☐
26. Do you work night shift or rotating shift? YES ☐ NO ☐
27. Did you ever do shift work? YES ☐ NO ☐

Thank you for your cooperation.