Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Sleep Questionnaire

Last Name: _____ First Name: _____ Birthdate: _____

1. Have had a sleep evaluation before? ☐ Yes ☐ No If yes, what device was recommended/do you use?

_____

2. Do you have COPD? ☐ Yes ☐ No If yes, do you use oxygen at home? ☐ Yes ☐ No

3. What time do you go to bed? _____ When do you wake up? _____

4. Do you have a hard time falling asleep? ☐ Yes ☐ No How long does it take for you to fall asleep? _____

5. Do you have racing thoughts, or do you plan your next day while you are waiting to fall asleep? ☐ Yes ☐ No

6. Do you have difficulty staying asleep? ☐ Yes ☐ No If yes, how many times do you wake up? _____

7. Do you take any medications to help you sleep? ☐ Yes ☐ No If yes, what medication and what dosage?

_____

8. Do you feel unrefreshed when you wake up to start your day? ☐ Yes ☐ No

9. When you are lying in bed waiting to fall asleep, do you have any unsettled or restless sensation in your legs? ☐ Yes ☐ No

10. Have you been told that you kick or twitch your leg at night while you are asleep? ☐ Yes ☐ No

11. Do you snore at night? ☐ Yes ☐ No How bad? ☐ Mild ☐ Moderate ☐ Loud

12. Have others told you that you stop breathing or you gasp for air during your sleep? ☐ Yes ☐ No

How often? ☐ Throughout the night ☐ Frequently ☐ Occasionally

13. Do you frequently wake up with: ☐ Dry mouth ☐ Headaches ☐ Excessive sweating ☐ Heartburn ☐ Aching jaw or teeth ☐ Choking or gasping ☐ Drool on the pillow ☐ Nasal congestion (although you had none when you went to sleep)

14. Do you have unusual behavior during your sleep? ☐ Yes ☐ No How often? _____

When did it start? _____ Describe behavior: _____

What part of the night do these occur? ☐ Within 90 min of sleep ☐ First 3 hrs of sleep ☐ Last 3 hrs of sleep

15. Do you occasionally wake up feeling paralyzed? ☐ Yes ☐ No

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16. Do you consume any of these substances and how much? ☐ Caffeinated beverages _____

☐ Alcoholic drinks _____ ☐ Tobacco products _____

17. Do you feel sleepy during the day? ☐ Yes ☐ No

18. Do you have difficulty concentrating during the day? ☐ Yes ☐ No

19. Do you take naps during the day? ☐ Yes ☐ No How often? _____ How long? _____

Do you dream during these naps? ☐ Yes ☐ No

20. Do you experience sudden loss of strength in your arms or legs during the day? ☐ Yes ☐ No

If yes, is it triggered by laughter or being frightened? ☐ Yes ☐ No

21. Do you feel drowsy or sleepy in these situations (as opposed to just feeling tired):

	Never become drowsy (0)	Rarely become drowsy (1)	Frequently become drowsy (2)	Always become drowsy (3)
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. movie theatre)	☐	☐	☐	☐
As a passenger in the car for an hour without a break?	☐	☐	☐	☐
If you had the chance to lie down in the afternoon?	☐	☐	☐	☐
Sitting quietly after lunch (which did not include alcohol)?	☐	☐	☐	☐
While talking to someone?	☐	☐	☐	☐
In a car while stopped for a few minutes in traffic?	☐	☐	☐	☐

22. Do you have high blood pressure? ☐ Yes ☐ No What is your average BP? _____

23. What is your body mass index (BMI)? _____

24. Have you gained weight that you couldn't lose? ☐ Yes ☐ No

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Today's Date:

Signature

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name:

Relationship: