Serenity SLEEP LAB

INITIAL QUESTIONNAIRE

NAME:_____ **DATE:**_____

SLEEP HISTORY _____**Height** _____**Weight**

What time do you usually go to bed?_____a.m./p.m.

What time do you usually get up?_____a.m./p.m.

Do you take naps? (YES) (NO) What time?_____ How long?_____

How long have you had a sleep problem?_____weeks/months/years

How many nights per week do you have a sleep problem?_____

Do you waken during the night with the sensation of choking?_____Gasping for breath?_____

Do you wake up in the morning with a dry mouth?_____ With a sore throat?_____

On the average, how often do you wake up during the night?_____

How many times in the night do you get up to urinate?_____

Has there been any loss of short term memory? (YES) (NO) Long term memory? (YES) (NO)

Do you dream? (YES) (NO) Are you bothered by nightmares? (YES) (NO)

Do you have breathing problems at night? (YES) (NO) If yes, describe _____
_____
_____
_____

Has anyone who has observed your sleeping commented on you having pauses in your breathing?_____

Have you been told that your legs jerk repeatedly while you are asleep? (YES) (NO)

Do you ever have an uncomfortable feeling in your legs at bedtime that is relieved only by moving your legs? (Y) (N)

Have you ever had a motor vehicle accident or near-accident because of sleepiness? (YES) (NO)

Do you find it difficult to fall asleep at night? (YES) (NO)

Do you wake up in the night and then find it difficult to fall asleep again? (YES) (NO)

Are you bothered by waking too early and not being able to get back to sleep? (YES) (NO)

On the average, how long are you awake in the morning before you finally get up?_____minutes

On the average, how long do you actually sleep during the night? _____hours

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