Arizona Center for Chest Diseases

PATIENT SLEEP QUESTIONNAIRE

Date _____ Name _____ Date of Birth _____

Age/Sex _____/_____ Height _____ Weight _____

HABITS AND LIFESTYLES

1. What is your normal bedtime? _____ AM/PM
2. What is your normal wake time? _____ AM/PM
3. On average how long does it normally take you to fall asleep? _____ Hrs. _____ Min.
4. On average how many hours of sleep to you achieve each night? _____ Hrs. _____ Min.
5. What is your primary sleep complaint?

6. What is the reason you physician sent you for the study?

7. Have you ever had a sleep study? Yes/No
8. Have you ever been diagnosed with a sleep disorder? Yes/No
9. Have you ever had surgery for a sleep problem or snoring? Yes/No
10. Does your work involve shift work or irregular hours that affects your sleep and wake times? Yes/No
11. Do you frequently travel across 2 or more time zones? Yes/No
12. Do you require the use of an alarm clock? Yes/No
13. Do you use medication to help you sleep? Yes/No