

Pottstown Medical Specialists, Inc.
The Sleep Wellness Center of Pottstown
1569 Medical Drive Suite 203 Pottstown, PA, 19464
Phone 484 945 0111 Fax 484 945 0122

ADULT SLEEP QUESTIONNAIRE

Patient's Name: _____ DOB: _____
Referring Physician: _____
Family Physician: _____
Primary Phone #: _____ Alternative #: _____
Emergency Contact #: _____ Phone #: _____

Describe your main sleep related problem(s) in your own words, including when and how this began and what treatments you have received in the past.

SLEEP HABITS/HISTORY

How many hours of sleep do you normally get per night? _____

On a typical day, what time do you usually.....

	Week Days	Weekends
Go to bed:	_____ am/pm	_____ am/pm
Get up:	_____ am/pm	_____ am/pm

Do You have/do any of the following? *(Check only the statements that apply)*

- Difficulty falling asleep Waking up during the night Waking up early in the morning
 Difficulty awakening Excessive daytime sleepiness Loud Snoring
 Wake up once you fall asleep? If so, how many times per night? _____
 Take a nap? If yes how many times _____
 Watch TV or read in bed before going to sleep? If YES, how long? _____
 Use sleeping aids or medicine? If YES, what kind(s) and how often? _____

BEFORE FALLING ALSEEP *(Check only the statements that apply)*

- Experience any racing thoughts?
 Experience feelings of depression?
 Kick or move your legs or arms in your sleep?
 Experience numbness, crawling, tingling or aching prior to falling?
 Experience an irresistible urge to move your legs or arms?

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How many times during the week do you experience these symptoms? _____

Symptoms better with movement?

BEHAVIOR DURING SLEEP *(Check only the statements that apply)* **Do you -**

Walk in your sleep?

Talk in your sleep?

Have any nightmares(frightening dreams) or night terrors?

Grind your teeth while asleep?

Have you been told you enact your dreams or thrash in bed?

UPON AWAKENING *(Check only the statements that apply)* **Do you -**

feel refreshed?

snore? If yes, it is loud and disturbing to others? _____

Did anybody notice that you stop breathing while I sleep? If yes, who _____

wake up choking, smothering or gasping for air?

wake up suddenly feeling fear, anxiety, or unhappiness?

wake up with your heart pounding, beating rapidly or irregularly?

wake up with a dry mouth or sore throat?

often have to go to the bathroom during the night?

wake up with a headache in the morning?

Hypersomnia/Sleepiness while awake *(Check only the statements that apply)* **Do you -**

Feel rested after you wake up? If no, explain _____

Have / nearly had any driving accidents due to sleepiness?

Tend to fall asleep while riding a bus or passenger in a car, reading or watching TV?

Have you had trouble doing your job because of sleepiness or fatigue?

Have reduced sexual interest or function?

Neurologic Symptoms

Do you get sudden weakness (even brief paralysis, unable to move) when laughing, angry, in an emotional situation or when you are surprised?

Have you had partial or total paralysis (unable to move extremities or other parts) during sleep?

Have you experienced hallucinations or dreamlike images or sounds (pleasant or terrifying) while falling asleep or waking up?

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