SLEEP DISORDERS INSTITUTE

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SLEEP DISORDERS INVENTORY

Instructions: Your responses to this questionnaire will offer your doctors a comprehensive overview of your sleep and sleep problems. In order to complete the questionnaire, you must respond to several "fill-in-the-blank" and "forced-choice" questions. Please answer all questions to the best of your ability, leaving no forced-choice item unanswered. Follow the instructions on the last page to submit the questionnaire to your doctor or to Sleep Disorders Institute for review.

IDENTIFYING INFORMATION

Today's Date ___/___/____

Patient's Name _____
Last First Middle

Address _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Cell phone _____ E-mail _____

Age _____ D.O.B. ___/___/____ Gender (circle) M F Non-binary Marital Status (circle) S M D

Height _____ Weight _____ Lbs. Neck Size _____ inches

Your occupation: _____

Your primary care physician:

_____ ( )
Name Address Telephone

Specialist who referred you to the Sleep Disorders Institute (if applicable):

_____ ( )
Name Address Telephone

Your referring doctor's area of specialty: _____

Place and date(s) of prior evaluation(s) for sleep disorders (if any):

_____ Date ___/___/____
Clinic or Hospital

_____ Date ___/___/____
Clinic or Hospital

OVERVIEW OF SLEEP PROBLEMS

1. Why are you seeking treatment at this time?

_____

2. Is there any aspect of your sleep environment that seems to contribute to your sleep problem? ..... ❑ Yes ❑ No

3. What is your usual bedtime (the time your get into bed)? ..... _____ AM/PM

4. What is your usual rise time (the time you get out of bed)? ..... _____ AM/PM

5. How long does it usually take you to fall asleep after you get into bed? ..... ____ hrs ____ mins

6. On average, how long would you say you actually are asleep each night? ..... ____ hrs ____ mins

7. Do you usually feel sluggish, sleepy, or fatigued upon awakening in the morning? ..... ❑ Yes ❑ No

8. Are you usually bothered by sleepiness during the day? ..... ❑ Yes ❑ No

9. Do you tend to fall asleep at inappropriate times? ..... ❑ Yes ❑ No

If yes, please give an example: _____

10. Do you usually have difficulty falling asleep at the beginning of the sleep period? ..... ❑ Yes ❑ No

11. Are you bothered by awakenings that occur during the night (after you've fallen asleep)? ..... ❑ Yes ❑ No

12. Have you been told that you snore loudly, or that your snoring disturbs others? ..... ❑ Yes ❑ No

13. Has anyone ever told you that you seem to have difficulty breathing or that you stop breathing during sleep? .... ❑ Yes ❑ No

14. Do you ever awaken gasping, choking, or "gulping for air?" ..... ❑ Yes ❑ No

15. Have you ever experienced "sleep attacks" (sudden, irresistible urge to sleep)? ..... ❑ Yes ❑ No

16. Do painful or unusual sensations of your legs interfere with your ability to fall asleep? ..... ❑ Yes ❑ No

17. Do you ever experience "twitching" or "jerking" of your feet or legs while asleep? ..... ❑ Yes ❑ No

18. Are you a shift worker (evenings, nights, or rotating shifts)? ..... ❑ Yes ❑ No

19. On average, do you consume more than 15 alcoholic drinks per week? ..... ❑ Yes ❑ No

20. Do you use any illicit drugs (e.g., marijuana, cocaine, crack)? ..... ❑ Yes ❑ No

Thank you for completing the Sleep Disorders Inventory. The information that you provided will assist your doctor in evaluating and treating your sleep complaint. If you have completed this questionnaire in your primary care doctor's office or specialist's office, you should review your answers with the doctor. You also may ask your doctor to submit your questionnaire to the Sleep Disorders Institute for review. Please use the e-mail or the street address indicated below for all correspondence. If you have completed this questionnaire at the Sleep Disorders Institute, you may request a copy for your files or your doctor's medical record.

Your health is our first concern. For information about the Sleep Disorders Institute and its affiliates, you may visit our website at www.sleepny.com. Please submit inquiries to info@sleepny.com.

Please return all completed questionnaires to:

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