

2110 W 24<sup>th</sup> Street  
Yuma, AZ 85364  
P (928)726-7106 F (928)726-6306

### SLEEP QUESTIONNAIRE

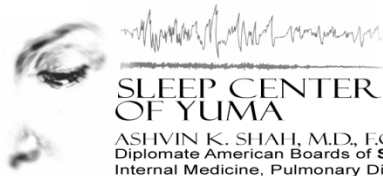
Name \_\_\_\_\_ Date \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

How did you hear about the Sleep Center of Yuma? Circle any that apply:

Your Physician                      Media (TV, Newspaper, Magazine)                      Website/Internet                      Family/Friend

- 1. What is your reason for visiting the sleep center today? \_\_\_\_\_
- 2. Describe your type of work and hours \_\_\_\_\_
- 3. What is your primary sleep complaint? \_\_\_\_\_
- 4. Have you been diagnosed with any type of sleep disorder in the past? \_\_\_\_\_  
If so, how long ago? \_\_\_\_\_ What were you diagnosed with? \_\_\_\_\_  
Where was the diagnosis made? \_\_\_\_\_
- 5. Do you have a regular sleep partner? \_\_\_\_\_
- 6. Have you ever had visual hallucinations or exceptionally vivid dreams while falling asleep? \_\_\_\_\_
- 7. Have you ever felt sudden muscle weakness when you laughed, got angry, or got surprised? \_\_\_\_\_
- 8. Have you ever felt paralyzed or unable to move just when falling asleep or waking up? \_\_\_\_\_
- 9. Have you fallen asleep while driving a car? \_\_\_\_\_
- 10. Do you snore? Circle one of the following: Never      Occasionally      Frequently      Always  
If you snore, rate yourself on a scale of 0 – 10 with 10 being the loudest \_\_\_\_\_  
How would your partner rate your snoring? \_\_\_\_\_  
What positions affect your snoring (if any)? Back      Right side      Left side      Stomach
- 11. Do you wake up with any of the following? Coughing      Choking      Acid taste      Rapid heart beat  
Dry mouth      Sore throat      Headache      Confused
- 12. Any recent weight gain? \_\_\_\_\_ If so, how much? \_\_\_\_\_
- 13. Have any of your family members been diagnosed with any sleep disorders? \_\_\_\_\_

Normal bed time _____ Normal wake time _____ Bed time on non-work days _____
Wake time on non work days _____ How many hours do you normally sleep? _____
How long does it take you to fall asleep? _____ How often do you get up at night? _____
What wakes you up? _____ Do you have a hard time getting back to sleep? _____
How long does it take you to get back to sleep? _____ Are you sleepy during the day? _____
Do you nap? _____ If so, are your naps refreshing? _____ Are you having memory problems? _____



**SLEEP CENTER OF YUMA**

ASHVIN K. SHAH, M.D., F.C.C.P., P.C.  
Diplomate American Boards of **Sleep Medicine**  
Internal Medicine, Pulmonary Diseases & Critical Care



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**SLEEP HYGIENE**

Do you perform any of the following in bed? Circle all that apply:

None    Read    Watch TV    Use computer    Worry    Eat    Write    Have arguments in bed

**PROBLEMS DURING SLEEP**

1. Do you have problems falling asleep due to any of the following? Circle which ones apply to you:

    Trouble relaxing      Racing thoughts      Pain or discomfort

- 2. Does waking too early and not being able to get back to sleep bother you? \_\_\_\_\_
- 3. Do you have prolonged periods when you are awake and can't get back to sleep? \_\_\_\_\_
- 4. Do you frequently check the clock when you are unable to sleep? \_\_\_\_\_
- 5. Has your mood, memory, or thought process recently changed? \_\_\_\_\_
- 6. Within the last year has depression, anxiety or stress interfered with your sleep? \_\_\_\_\_
- 7. Do you have nightmares? \_\_\_\_\_ Any history of bed wetting? \_\_\_\_\_
- 8. Do you grind your teeth in your sleep? \_\_\_\_\_ Do you use a device? \_\_\_\_\_
- 9. Do you thrash around in your sleep? \_\_\_\_\_ Are your covers messy in the morning? \_\_\_\_\_
- 10. Have you ever hit or kicked your bed partner in your sleep? \_\_\_\_\_
- 11. Do you have episodes of flailing your arms/kicking your legs/screaming in your sleep? \_\_\_\_\_  
If so, do you recall dreaming during these episodes? \_\_\_\_\_ Or becoming confused? \_\_\_\_\_  
Do you remember these episodes in the morning? \_\_\_\_\_
- 12. Do you walk in your sleep? \_\_\_\_\_ Have you ever awakened screaming in your sleep? \_\_\_\_\_
- 13. Has anyone ever said you stop breathing in your sleep? \_\_\_\_\_

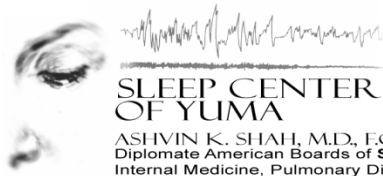
**SLEEP DISTURBANCES**

My sleep is frequently disturbed by the following (circle all that apply):

None    Sinus or cold symptoms    Leg discomfort    Choking or gasping for air    Frightening dreams  
Need to urinate    Indigestion    Pain    Hunger    Bed partner    Pets    Asthma    Cough    Children  
Headaches    Nausea    Thirst    Noise    Stress    Shortness of breath

List any other symptoms that disturb your sleep \_\_\_\_\_

\_\_\_\_\_



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**How likely are you to doze off or fall asleep in the following situations?**

Use the following scale to choose the most appropriate number for the situation:

0 – would never doze    1 – slight chance of dozing

2 – moderate chance of dozing    3 – high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3
As a passenger in a car for about an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Watching TV	0	1	2	3

**HABITS**

Do you smoke? \_\_\_\_\_ Chew? \_\_\_\_\_ If so, how much per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how many (average) work days? \_\_\_\_\_ Weekends? \_\_\_\_\_

Do you drink caffeine? \_\_\_\_\_ If so, what kind?    Soda    Coffee    Tea    Energy drinks

How many per day? \_\_\_\_\_

**MEDICAL HISTORY**

Circle all that apply:

None      High blood pressure      Nasal/ sinus problems      Claustrophobia

Depression      Panic attacks      Heart disease      Lung disease      GERD      Diabetes

Thyroid disease      Seizures      Stroke      Other throat or nose surgery

Have you ever had surgery for sleep apnea? \_\_\_\_\_ If so, when? \_\_\_\_\_