SLEEP DISORDERS CENTER

West Jefferson Medical Center

PROUD MEMBER OF LCMC HEALTH

SCREENING QUESTIONNAIRE

Please answer the following questions to determine if you might be at risk. If you would like to have the Sleep Disorders Center discuss the results of this form with you, please fill out your name and contact information and you will be contacted within 3 business days. If you haven't heard from us with that time period, feel free to call us 504-349-6966.

Name: ____________________ Phone Number: ____________________

Email Address: ____________________

1. What is your main sleep complaint?
   Snoring   Excessively Tired   Gasping for Air/Stops Breathing   Other

2. How long have you had this sleep problem? ____________________

3. Does any member of your family have a sleep disorder?
   If yes, what is the person's relationship to you?
   What type of disorder?

4. How would you describe your usual night's sleep?

5. Do you have difficulty falling asleep when you first go to bed?
   Frequently   Occasionally   Rarely   Never

6. How often do you wake up at night?

7. How many trips to the bathroom do you take each night?

8. Do you awaken in the night and then can not go back to sleep?
   Frequently   Occasionally   Rarely   Never

9. Do you snore?
   Frequently   Occasionally   Rarely   Never

10. How has your snoring been described?
    Loud   Moderate   Mild

11. Have you been told you stop breathing while you sleep?
    Frequently   Occasionally   Rarely   Never

12. Do you wake up with your heart beating rapidly?
    Frequently   Occasionally   Rarely   Never

continued on reverse

13. Do you wake up gasping, wheezing, or short of breath?
    Frequently   Occasionally   Rarely   Never

14. How do you feel after a typical night's sleep?
    Refreshed   Fairly Refreshed   Somewhat Tired   Very Tired

15. Do you wake up with irritated or scratchy throat?
    Frequently   Occasionally   Rarely   Never

16. Do you wake up with morning headaches?
    Frequently   Occasionally   Rarely   Never

17. Do you sleep or get very sleepy whenever you are inactive (such as at meetings, watching TV, at the movies or in church)?
    Frequently   Occasionally   Rarely   Never

18. Do you have trouble at work because of sleepiness?
    Frequently   Occasionally   Rarely   Never

19. Have you ever fallen asleep while driving?
    Frequently   Occasionally   Rarely   Never

20. Do you fall asleep no matter how hard you try to stay awake?
    Frequently   Occasionally   Rarely   Never

21. Do you take daytime naps?
    Frequently   Occasionally   Rarely   Never

22. If so, after a nap do you feel refreshed?
    Frequently   Occasionally   Rarely   Never

23. Do you lose muscle control or strength with emotions (anger, laughter, or sadness).
    Frequently   Occasionally   Rarely   Never

24. Do you experience vivid dreaming?
    Frequently   Occasionally   Rarely   Never

25. Do you feel unable to move when you are waking up of falling asleep?
    Frequently   Occasionally   Rarely   Never

26. Do you experience leg pain or leg movements during the night?
    Frequently   Occasionally   Rarely   Never

    If so, do they awaken you?   Yes   No

27. Do you ever feel that you can not keep your legs still at night; that you must move them or walk around?
    Yes   No

28. Do you have difficulty concentrating or memory problems?   Yes   No

Questions? Call the West Jefferson Sleep Disorders Center at 504.349.6966

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