Name: _____

DOB: _____

SLEEP DISORDERS CENTER

General Sleep Assessment

Complete the following questionnaire by filling in the blanks and/or placing a check mark in the appropriate area.

What time do you usually go to bed?		_____	AM	PM
Do you have difficulty falling asleep initially?	Yes No			
If you have difficulty, how long does it take to fall asleep?		_____		
Do you plan tomorrow's activities while lying in bed?		Yes	No	
Do thoughts racing through your mind keep you from sleeping?		Yes	No	
Do thoughts keep you up after awakening during the night?		Yes	No	
Do you have difficulty staying asleep during the night?		Yes	No	
If yes, how many times do you wake up during the night?		_____		
How long does it take you to fall back to sleep?		_____	Minutes	Hours

Name: _____

DOB: _____

Previous Sleep Evaluation and Treatment

I previously have had a sleep study. When?: _____ Where?: _____

I am currently or have used titration therapy for home use. Pressure (if known)_____ cm H20

I have had surgical treatment for a sleep disorder. When? _____

I am currently or have previously taken prescription sleep medication.

I am currently or have previously taken over-the-counter sleep medication.

I use oxygen. Number of liters (if known) _____ All day Only at night

List any recent surgeries (including year)

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