

SLEEP MANATEE – Sleep Disorders Questionnaire



Florida Sleep Specialists

Name: _____

Date: _____

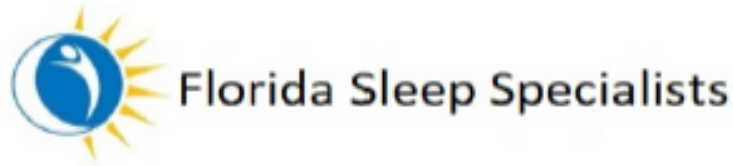
1. Please describe your sleep problem. Be as specific as possible.

(For example, “My bed partner can’t sleep because of my snoring” ; “ I sometimes fall asleep unintentionally” ; “ My bed partner says I stop breathing in my sleep, and it worries him/her” ; “I have trouble getting to sleep at night”; “ I’m sleepy most of the time”; “ I awaken too many times at night”; “Recently, my sleep hasn’t been as refreshing as it once was”; “My bed partner says my legs jerk all through the night”; “ I often awaken with heartburn or choking on stomach acid”; etc.)

- 2. When did your sleep problems begin? _____
- 3. What time do you usually turn the lights off to go to bed? _____
- 4. What time do you usually awaken for the day? _____
- 5. How long does it typically take you to fall asleep each night after the lights are turned off? _____
- 6. How many times do you awaken during a typical night? _____
- 7. How many minutes are you typically awake during these awakenings? _____
- 8. List the reasons that typically cause you to wake up during the night:

- 9. When you awaken in the morning, do you feel refreshed? YES NO
 If NO, describe how you feel: _____
- 10. Do you feel you are sleepier during the day that you should be? YES NO
 If YES, at what age did you begin to experience excessive sleepiness? _____
- 11. Do you sometimes doze or fall asleep when you don’t intend to? YES NO
- 12. Do you sometimes experience dreams just as you are falling asleep? YES NO
- 13. When you are falling asleep, do you ever see vivid, life-like images? YES NO
- 14. Have you ever experienced sudden **muscle weakness** (not dizziness, not fainting) associated with an emotional state (for example: laughing, anger, fear) that made it difficult to stand or difficult to maintain control of your head or arms or hands? YES NO
- 15. Have you ever experienced an occasion during which you awoke fully, but found it impossible to move for a minute or so? YES NO
 If YES, how often does this happen? _____
- 16. Have you ever felt paralyzed as you were falling asleep? YES NO
 If YES, how often does this happen? _____

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17. Do you ever awaken with headaches that seem to fade away after a few minutes or an hour or so? YES NO

If YES, how often do these occur? _____

18. Do you sweat in your sleep even when the room is cool? YES NO

19. Do you ever experience a strong sensation of discomfort in your legs when you relax or when you lie down to sleep? YES NO

If YES, describe this sensation: (Examples: cramps, a restless sensation requiring movement, ect.)

20. Have you been told that you kick or move your legs repeatedly during you sleep? YES NO

If YES, how often do you do this? (e.g. every night, once a week)

21. Do you or have you ever sleepwalked, or awakened out of your bed with no clear recollection of the preceding events? YES NO

If YES, describe the specific events:

22. Do you physically act out you dreams during your sleep? YES NO

23. Have you ever damaged property or harmed you bed partner or others during your sleep? YES NO

If YES, please describe these specific events and how often do these events

occur: _____

24. Do you currently have seizures (epilepsy) or have you ever been treated for seizures in the past? YES NO

25. Have you ever fallen asleep while driving or had an automobile accident related to sleepiness? YES NO

26. Do you work night shift or rotating shift? YES NO

27. Did you ever do shift work? YES NO

Thank you for your cooperation.