Sleep Consult Questionnaire

Name:_____

Date:_____

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1. Do you sleep more than 7 hours per night? YES NO
2. Do you wake up during the night? YES NO
3. Do you feel tired throughout the day? YES NO
4. Do you snore? YES NO
5. Have you been diagnosed with a sleep disorder? YES NO
6. If yes to question #5, have you used or are you currently using a CPAP, sleep appliance and/or oral medications? YES NO

7. Clinical symptoms – Please check all symptoms that describe your sleep.

_____Excessive daytime sleepiness	_____Insomnia
_____Impaired cognition	_____Mood disorders
_____Morning headaches	_____Witnessed sleep apnea
_____Restless legs	_____Restless or disturbed sleep
_____Snoring	_____Nocturnal choking/gasping

8. Health history – Please check all conditions that you may have.

_____High blood pressure	_____History of stroke
_____Ischemic heart disease	_____Diabetes
_____Heart failure/Cardiovascular disease	_____BMI > 35 (morbid obesity)
_____Abnormal oropharyngeal exam	_____Pulmonary disease
