Sleep Survey

Your answers to the following preliminary sleep survey will help our sleep medicine specialists determine the appropriate course of treatment.

Name ______________________________ Date: ______________________

DOB: ____________ Age: _____ Weight: ________ Height: ______ Gender: Female ☐ Male ☐

Do you snore? (loud enough to be heard through closed doors) ☐ Yes ☐ No

Do you feel tired, fatigued, or sleepy during the day? ☐ Yes ☐ No

Has anyone observed you stop breathing while you sleep? ☐ Yes ☐ No

Are you being treated for high blood pressure? ☐ Yes ☐ No

Do you have trouble with concentration or memory? ☐ Yes ☐ No

Do you have occasional morning headaches? ☐ Yes ☐ No

Do you fall asleep while in meetings, while reading, while watching TV, while driving? ☐ Yes ☐ No

Do you suffer from depression or mood changes? ☐ Yes ☐ No

Do you have trouble going to sleep or staying asleep? ☐ Yes ☐ No

Do you experience an aching, crawling or uncomfortable feeling in your legs when you are trying to sleep? ☐ Yes ☐ No

How would you rate your sleep? ☐ POOR ☐ FAIR ☐ GOOD

Do you have:

High Blood Pressure? ☐ Yes ☐ No

Heart Disease? ☐ Yes ☐ No

Stroke? ☐ Yes ☐ No

Sleep Apnea? ☐ Yes ☐ No

If you answered yes to 2 or more questions on this survey, please contact The Sleep Center to schedule a preliminary consultation. A referral from your primary care doctor is needed in most cases.

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