RESPIRATORY CONSULTANTS
OF GEORGIA
SLEEP CENTER

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
ACCREDITED
MEMBER CENTER

NEW PATIENT SLEEP QUESTIONNAIRE

NAME: _____ DATE: _____

YES	NO	
___	___	I feel sleepy during the day
___	___	I snore
___	___	I feel tired when I wake up in the morning
___	___	I have been told I stop breathing
___	___	I am restless when I sleep
___	___	I wake myself gasping or choking
___	___	I have memory loss or difficulty concentrating
___	___	I sleep walk
___	___	I sleep talk
___	___	I act out my dreams
___	___	I get fatigue during the day
___	___	I wake-up with morning headaches
___	___	I wake up more than 3 times per night
___	___	I take naps more than 3 times per week
___	___	I find myself dosing off when I really did not want to
___	___	I have had muscle weakness when startled or laughing
___	___	I have felt paralyzed upon falling asleep or waking up
___	___	I have seen images in my room upon falling asleep or waking up
___	___	My legs kick or jerk at night
___	___	I have an uncontrollable urge to move my legs when I am sitting or lying down
___	___	I get leg cramps
___	___	I have difficulty falling asleep
___	___	I have difficulty staying asleep
___	___	I get anxious, depressed or easily irritable
___	___	I am often not tired at bed time
___	___	I would like to sleep-in later in the mornings
___	___	I like to go to bed early
___	___	I like to wake up early in the mornings

What time do you go to bed? _____ How long does it take you to fall asleep? _____
How would you describe the quality of your sleep: **a**. Good **b**. Poor **c**. Some good nights some bad
Do you take medications to help you sleep and if so, what do you take _____
I wake up at (what time) _____ I get out of bed at (what time) _____
How many 8oz. servings of caffeinated beverages do you drink including, coffee, tea, soda _____

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