Weill Cornell Center for Sleep Medicine
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# Sleep Questionnaire

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Patient name: _____ Age: _____ DOB: ____/____/_____

Marital status: _____ Gender: ☐ M ☐ F Height:____ft_____in Weight:_____ lbs

Ethnicity: _____ Referred by:_____

Reason for the visit: ☐ Insomnia ☐ Sleep apnea ☐ Other: _____

Have you been previously evaluated for a sleep disorder? ☐ No ☐ Yes

Have you ever had an overnight sleep study? ☐ No ☐ Yes

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I. EPWORTH

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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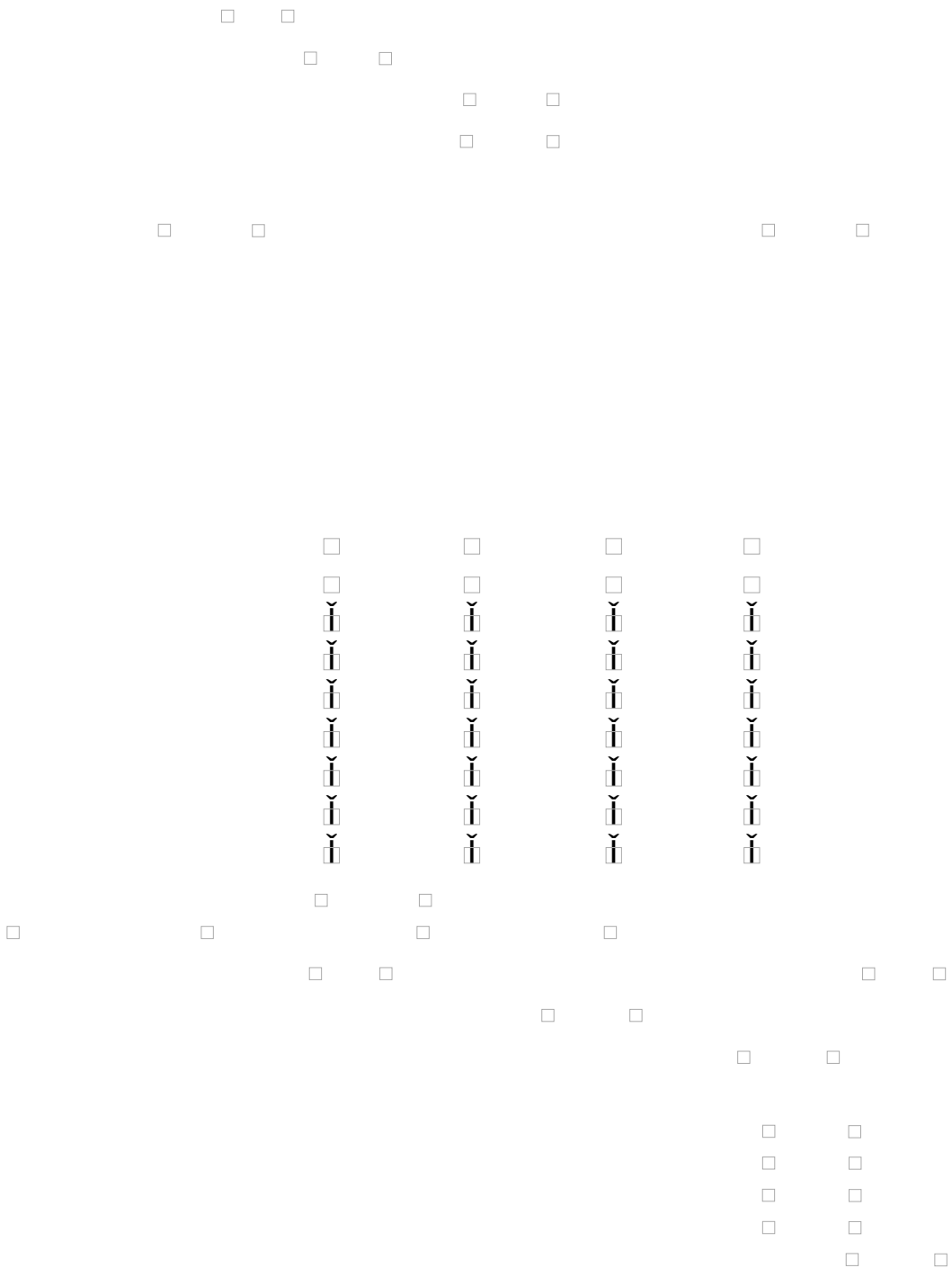
III.



IV. RLS - *Please check the appropriate box:*

Do you kick your legs at night, prior to or during sleep? ☐ No ☐ Yes

Do you ever experience a desire to move your legs due to discomfort or disagreeable sensations in your legs? ☐ No ☐ Yes

Do you sometimes feel the need to move to relieve the discomfort, for example by walking or rubbing your legs? ☐ No ☐ Yes

Are these symptoms worse later in the day or at night? ☐ Not applicable ☐ No ☐ Yes

Are these symptoms worse when you are at rest, with at least temporary relief by activity? ☐ Not applicable ☐ No ☐ Yes

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V. CPAP *(for CPAP users only - skip this section if you do not use CPAP):*

How many nights per week do you use your CPAP? _____ nights/week

How many hours per night do you use your CPAP? _____ hours/night

While using CPAP, are any of the following problems present?

| | | |
|---|---|---|
| ☐ Snoring | ☐ Dry mouth/dry nose | ☐ Mask marking the face |
| ☐ Gasping or choking | ☐ Stuffy or running nose | ☐ Bridge of nose discomfort |
| ☐ Witnessed apnea | ☐ Ear pain/ear popping | ☐ Skin sore or acne from mask |
| ☐ Unrefreshing sleep | ☐ Irritated, dry or red eyes | ☐ Machine noise |

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VI. SOCIAL HABITS: Profession/Job: _____

Occupational Status: ☐ Actively working ☐ Retired ☐ Disabled ☐ Shift worker

Are you sedentary (no more than 10 minutes of uninterrupted physical activity) during the day? ☐ No ☐ Yes

Do you exercise for more than 30 minutes at least two times a week? ☐ No ☐ Yes

Do you smoke or have you ever smoked? ☐ No ☐ Yes

If so, how many cigarettes a day?_____ For how long?_____

If you quit smoking, how long ago did you quit?_____364.897 Tm [(__)-3(_)9(__)7(__)-3(_2264/T

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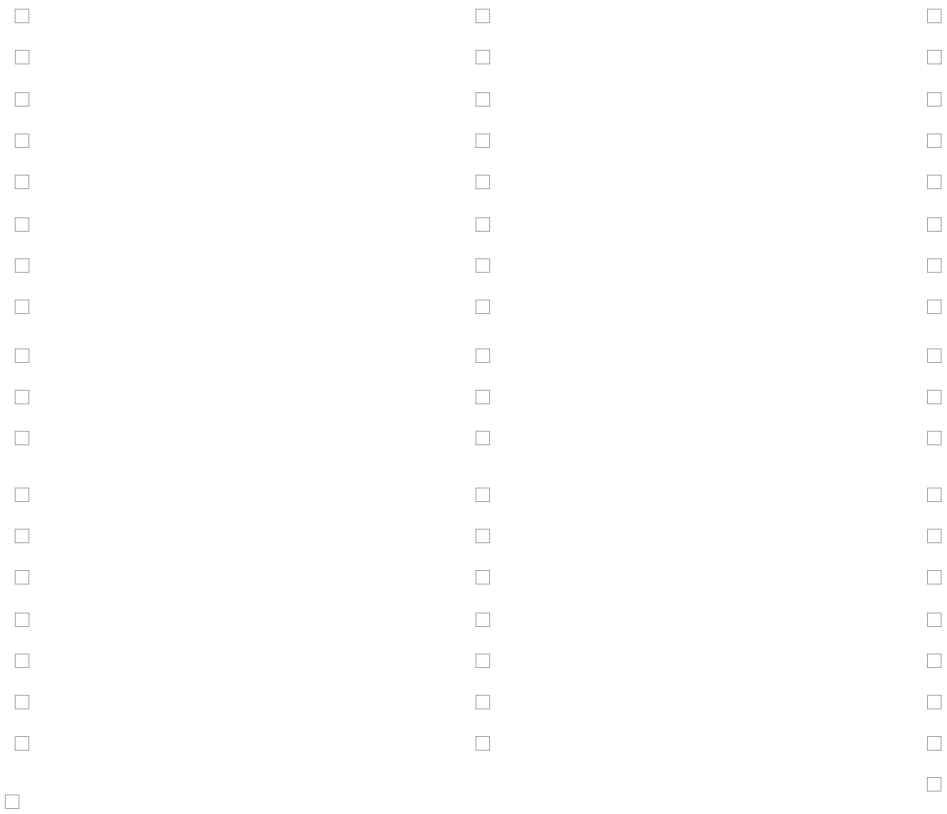

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**Forms**

**Authorization To D Ø D gɁ**

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