

Neurology Associates of Monroe County
3 Parkinson's Road
East Stroudsburg, PA 18301
570-424-1102

Name _____ Date _____ Referring Doctor _____

Why are you here? _____

What time do you wake up? School/work nights _____ Other nights _____

Do you awaken during the night? YES or NO
If yes, what wakes you up? _____
How many times in a night? _____
How many times do you wake to urinate? _____
Do you have trouble falling back to sleep? YES or NO
If so, what do you do? _____

What time do you start school/work? _____
Do you drive to work/school? YES or NO
If so, how many minutes? _____

Have you ever fallen asleep while (check all that apply)
_____ Driving _____ At Parties _____ Watching TV/movies
_____ At Work _____ Eating _____ in Class / Meetings
_____ In conversation _____ Reading _____ Having sexual intercourse
_____ Other (please explain) _____

Do you snore? YES or NO
Does your snoring disturb others? YES or NO
Have you awakened yourself by snoring? YES or NO
How long have you been snoring? YES or NO
Has your snoring progressively gotten worse? YES or NO
Has your snoring changed? YES or NO
If yes, explain _____

Has anyone told you that you stop breathing? YES or NO
Do you snort, gasp or choke at night? YES or NO

Do you awaken with a morning headache? YES or NO
Do you take medication for it? YES or NO
If so, what? _____
How long before the headache is gone? _____

In the past 6 months have you experienced:
Trouble concentrating? YES or NO
Poor Memory? YES or NO
Personality changes? YES or NO
Sexual dysfunction? YES or NO

Have you ever experienced the following in your arms and legs?
Weakness YES or NO
Tingling YES or NO
Twitching YES or NO
Cramping YES or NO
Strange sensations YES or NO
Restless legs YES or NO

Does your bed partner complain of frequent kicking? YES or NO

As a sleeper, do you consider yourself to be quiet or restless

Have you ever experienced:
The inability to move your arms or legs upon awakening? YES or NO
General weakness or falls with laughter or strong emotion? YES or NO
Visual hallucinations when falling asleep? YES or NO
Other unusual sleep problems? YES or NO

Do you dream? YES or NO
Vivid YES or NO
Scary YES or NO
Recurring YES or NO

Have you ever accidentally wet the bed? YES or NO

Do you get chest pain? YES or NO

Do you get short of breath lying down? YES or NO

Do you get short of breath walking? YES or NO

Do your ankles swell? YES or NO

Do you get heartburn? YES or NO

If so, does it bother you at night? YES or NO

In the past year has your weight changed? YES or NO

Fill in the blanks: I have lost _____pounds gained _____pounds

Have you ever taken prescription or non-prescription medications to help you to sleep? YES or NO

If so, what? _____

Have you ever taken prescription or non-prescription medications to help you stay awake? YES or NO

If so, what? _____

Does anyone in your family have sleep problems? YES or NO

If so, who and what problem? _____

Have you or do you use any recreational drugs? YES or NO

What? _____ How much? _____ How often? _____

How much of the following do you drink each day?

Caffeinated: coffee _____ soda _____ tea/hot/iced/other _____

Decaffeinated: coffee _____ soda _____ tea/hot/iced/other _____

How long before bed do you use?

Caffeine _____ Tobacco _____ Alcohol _____ Physical exercise _____

What position do you sleep in (circle all that apply to you)?

Back Side Stomach

Have you ever had sleep studies done before? YES or NO

If so, where? _____

****If you had a screening appointment with our physician, please STOP HERE.****

****If you have not seen our physician for a sleep evaluation, please COMPLETE **
the remainder of this questionnaire.**

Please list all current medications

Medication	Dose	Times	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List your present and past medical problems: _____

Have you ever had surgery? YES or NO
If so, what? _____

What medical problems run in your family? _____

What do you do for a living? _____

Have you ever used tobacco? YES or NO
What type _____ How much _____ How long _____

Have you or do you drink alcohol? YES or NO What?
How much? _____ How often? _____

What time do you go to bed? School/work nights other nights

What time do you try to fall asleep? _____

How long does it take you to fall asleep?
on your best night? _____
on your worst night? _____
on an average? _____

Are you sleepy during the day? YES or NO
If so, what time(s)? _____

Do you take planned naps? YES or NO
Do you feel refreshed after a nap? YES or NO
How long are your naps? _____
What time do you nap? _____
How often do you nap? _____ times per day / week / month
