

Sleep Study Questionnaire



Last Name: _____	First Name: _____	DOB: _____	Age: _____
Today's Date: _____	SSN: _____	Gender: _____	Height: _____
		Race: _____	Weight: _____

Please describe your sleep problem, or why your doctor requested a sleep study for you:

Have you had a sleep study before? Yes | No If yes, when and where? _____

What were the results? _____

Please list any treatments, therapies or medications you are currently using to treat your sleep problem
(Medications, stimulants, sleep-aids, CPAP or Bi-PAP therapy, dental appliances, etc.)

Current Status: Complete this section on the day of your study

When did you go to bed last night? _____ When did you wake this morning? _____

If you took any naps today, when and how long? _____

Do you have nasal congestion, a cold or a cough? _____

If you are in any pain or discomfort today, please describe it below:

General Medical History – Please check all that apply

20.0019



Olathe Medical Center
20333 West 151st Street
Olathe, Kansas 66061

**SLEEP HISTORY
QUESTIONNAIRE**
SLEEP DISORDERS CENTER

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O.M.C. No. 2074

PLACE
PATIENT LABEL
HERE



High blood pressure		Emphysema		Deviated Septum	
Acid Reflux		Shortness of Breath		Chronic Sinus Infection	
Heart Attack		Chronic Pain/Fatigue		Anxiety/Depression	
Stroke		Fibromyalgia		Head Injury	
Diabetes (Type I or II)		Cancer			
Heart Disease		Anemia			
Asthma		Renal Insufficiency			
COPD		Thyroid Problems			

Sleep History – Please check any that may apply (you may wish to consult your bed partner)

Snoring		Claustrophobia	
Grind your teeth or jaw clenching		Sleep with your head elevated	
Difficulty going to sleep (insomnia)		Awaken in bed, unable to move	
Awaken with shortness of breath or gasping		Sudden weakness with exciting events	
Nap on a daily basis		Hallucinations before or after sleep	
Awaken with stomach acid taste in mouth		Nightmares on a regular basis	
Restless legs, frequent kicking at night		Difficulty staying awake during the day	
Falling asleep while driving		Wear supplemental oxygen but only at night	

Allergies

Are you allergic to tapes or adhesives? _____ Are you allergic to Latex? _____

Please list all other allergies you have:

Diet and Medications

Estimated number of caffeinated beverages and foods (chocolates) per week:

Estimated number of alcoholic beverages per week:

Do you or have you used tobacco products? _____ Enter daily amount and number of years:

Medications – please list all below:

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