Sleep Questionnaire/RevolutionaryMD

Name:_____ **Date:** _____

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and for many physiological functions. Please answer the following questions as accurately and fully as possible. For Yes / No questions, please circle the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

Sleep Problems:

1. Do you have a sleep problem that has been diagnosed? _____
2. Do you feel that you have a sleep problem and how would you describe it? _____

_____

Sleepiness Questions:

3. Do you feel well rested in the morning? Yes / No Please explain_____
4. Are there times during the day or evening that you feel sleepy and what times are these? _____

_____

5. What do you do to wake up when you feel sleepy?_____
6. Have you ever had an accident at work, at home or on your job because you were sleepy? Yes / No
   If "Yes," please explain _____
7. Do you take naps and for how many minutes and at what time of day? _____
8. Do you feel well rested after a nap?_____

Insomnia Questions:

9. Can you usually fall asleep within 20 minutes of lying in bed? Yes / No
10. How long does it usually take you to fall asleep? _____
11. Do you ever feel so wired at night that it is difficult to fall asleep? Yes / No
12. Have you had a saliva cortisol test and, if so, do you remember if your night time level was high? _____
13. Do you now take (or have you tried) any of the following to fall asleep and, if so, how many times per week do you take them? Please answer with an E for effective or an N for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien				
Sonata				
Lunesta				
Ativan/Valium				
Restoril				
Magnesium				
5-htp				
Kava				
Melatonin				
Other? (Please specify_____				

14. Do you wake up in the middle of the night and, if so, how many times and for what reasons? Yes / No ___
15. Do you have any trouble falling back asleep when you wake up and, if so, how long does it usually take you? _____
16. Does feeling the need to move your feet or legs at night keep you awake or have you been diagnosed with Restless Legs Syndrome? _____
17. Do you have disturbing dreams at night? _____

Caffeine and Other Stimulants:

18. If you drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use…	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas (Coke, Pepsi, Mountain Dew, etc.)			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19. What medications are you on and what time do you take them? _____

_____

_____

Stress and Stress Reduction:

20. What kind of stress have you been under in the past few months? _____

_____

21. What do you do for stress management? _____
22. Do you have a journal to write in that is near your bed? Yes / No
23. Do you exercise aerobically and, if so, what do you do, how often do you exercise, and at what time of day? _____

_____

Sleep Hygiene:

24. What time do you usually go to bed? _____
25. What time do you usually wake up? _____
26. Do you feel that you go to bed too late? _____
27. If you feel that you go to bed too late, what time would you like to go to bed? _____
28. Do you watch TV in the evenings and, if so, what hours do you watch it? _____
29. Is the TV in your bedroom or in a family room? _____
30. On the weekend or days off do you vary your sleep schedule? _____
31. How many hours are you physically in your bed? _____

32. How many hours of the time spent in bed are you actually asleep? _____
33. Do you have much light coming into your bedroom and what can you see at night without any lights on? _
34. Do you have little children who wake you up? _____

Bedroom, Breathing and Environment:

35. Is the air in your bedroom clean or dirty? _____
36. Are there any unusual smells in your bedroom? If so, please describe _____
37. Do you snore, stop breathing, or have trouble breathing at night? _____
38. Do you use Breathe-Easy strips on your nose and do they help you to breath? _____
39. Do you have carpets or hardwood floors in your bed room? _____
40. How many rooms in your home have carpets and how old are the carpets? _____
41. What type of heat is in your home: forced air or radiant? _____
42. How often do you change the furnace filter in your home? _____
43. Have you seen any black mold in your window sills or in a basement? _____
44. Do you have a HEPA air filter for your bed room and, if so, what brand is it and how long do you run it each day? _____
45. What type of vacuum cleaner do you use and does it have a HEPA filter in it? _____

_____

46. How often do you clean the dust in your bedroom? _____
47. Do you sleep with an animal that snores or moves around and disturbs you? _____
48. Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep? _____
49. Do noises wake you up? If so, what are they? _____
50. Do you live on a noisy street? _____
51. Do you feel safe in your bed at night? _____

Bed, Pillows, and Pain:

52. What type of bed do you have and what size is it? _____
53. Do you wake up because of pain and, if so, at what time and where is the pain? _____

_____

54. What type of pillow is most comfortable for you and what type have you tried that did not work? _____

_____

55. Do you use body pillows and, if so, how many and how do you use them? _____

_____

Please call to schedule an appointment to review this survey with Dr. Grover.

You can send this to our secure fax prior to appointment at 303-974-5945 if you'd like or simply bring in.