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**SLEEP QUESTIONNAIRE**  
**Chief Complaint and History**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: \_\_\_\_\_ Living Arrangements: \_\_\_\_\_

Occupation: \_\_\_\_\_

Details of chief complaint: \_\_\_\_\_ Duration of complaint: \_\_\_\_\_

Improved by doing: \_\_\_\_\_

**Do you experience the following?**

**Please check the following symptoms you experience:**

- Loud snoring     Snorting
- Gasping         Episodes of Apnea
- Weight gain     Sinus problem
- Snoring due to body position

**Symptoms that occur during sleep (patient may be unaware, bed partner may fill out)**

- Twitching or kicking arms/ legs     Chewing
- Nightmares                               Sleep walking
- Screams                                     Sleep talking
- Violent behavior

**Symptoms that occur while awakening:**

- Headaches
- Wheezing or sobbing
- Racing heart or palpitations
- Leg cramps
- Heartburn
- Numbness or tingling

**Daily Schedule:**

Time of work: \_\_\_\_\_ Time of school: \_\_\_\_\_  
Time of meals: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Snacks \_\_\_\_\_  
Time of exercise: \_\_\_\_\_ Do you wake up fresh in the morning? \_\_\_\_\_

**Average intake of the following:**

Caffeine: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Smoking: \_\_\_\_\_

**Bedtime Schedule:**

Does a bedtime routine exist?  Yes  No  
Estimated time of sleep onset: \_\_\_\_\_ Usual bedtime: \_\_\_\_\_  
Number awakenings: \_\_\_\_\_ To use the washroom: \_\_\_\_\_  
Final wake-up time: \_\_\_\_\_  
Is your awakening:  Spontaneous  Alarm  By other people

**Sleep Settings: (Check the following factors that disturb your sleep)**

- Noise
- Extreme temperature
- Uncomfortable sleep surfaces
- Frequently changing sleep positions
- Age of mattress: \_\_\_\_\_

**Insomnia: (Check which describes your current sleep problem)**

- Difficulty falling asleep
- Frequent awakenings
- Early morning awakening with inability to return to sleep

**Do you fall asleep at inappropriate times:**

- At work
- While driving
- Sitting on toilet
- During sexual intercourse

**Restless Leg Syndrome**

1. Do you sometimes have an urge to move your legs, often associated with the Creepy, crawly or achy sensations? (Please circle)
2. Do you get relief or temporary ease from the urge or leg sensations when you move?  Yes or  No
3. Do your leg symptoms get worse when you are resting or inactive? (Please circle)
4. Do your leg symptoms get worse at night?  Yes or  No

**Adjustment sleep disorder**

Recent stressful events in your life:

\_\_\_\_\_

Recent positive life events:

\_\_\_\_\_

Are you anxious when preparing for sleep?    Yes                       No

Do you worry about insomnia and it's effects on your performance at work  
or at home the following day?                      Yes                       No

Do you sleep better in an unfamiliar sleep setting?                      Yes                       No

Do you experience sleep problems with the following?

Irregular bedtimes       Late night exercise       Watching TV in bed

Going from work directly to bed

Behaviors and thoughts that accompany nocturnal awakenings:

Do you eat at night or during your sleep time?                      Yes                       No

Do you drink alcohol at night or while your sleeping?    Yes                       No

After sleeping eight hours do you feel rested or refreshed? \_\_\_\_\_

**B. EXCESSIVE SLEEPINESS**

For each of the following situations, tell us tell us how you would rate your  
likeliness to dose off ( whether or not you intend to):

0 = Never    1 = Slight chance    2 = Moderate chance    3 = High chance

Situations:

- Sitting and reading \_\_\_\_\_
- Sitting inactive in a public place like a theatre \_\_\_\_\_
- As a passenger in a car for a hour with a break \_\_\_\_\_
- Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_
- Sitting and talking with someone \_\_\_\_\_
- Sitting quietly after lunch without alcohol \_\_\_\_\_
- In a car while stopped for a few minutes in traffic \_\_\_\_\_

**Does drowsiness interfere with daytime activities?**

A.M. sleepiness     P.M. sleepiness

How often, during the day, do you nap? \_\_\_\_\_ How long each time? \_\_\_\_\_