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Oneonta, AL 35121

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Pell City, AL 35125

PULMONOLOGY • SLEEP • ASTHMA • CRITICAL CARE

Pulmonary Associates
of the Southeast PC

Gardendale Clinic
2215 Decatur Highway, Suite 117
Gardendale, AL 35071

Sylacauga Clinic
Medical Arts Building, Suite 124
120 South Anniston Avenue
Sylacauga, AL 35150

Chelsea Clinic
16691 Hwy 280
Chelsea, AL 35043

Russell G. Beaty, M.D • Sandra K. Gilley, M.D. • Allan R. Goldstein, M.D. • W. Bishop Kelley, M.D. • Karl T. Schroeder, M.D. • Alan Q. Thomas, M.D.

SLEEP DISORDER QUESTIONNAIRE

Name_____ DOB_____

1. During the week, what time do you normally go to sleep? _____
2. During the week, what time do you normally wake up? _____
3. On your weekends, or during your time off, do you sleep more than you do during the week? _____
4. Do you have memory lapses? _____
5. Do you have difficulty concentrating? _____
6. Do you find that you are sleepy all the time? _____
7. Do you fall asleep when you are trying to watch television, read a book, or perform other tasks? _____
8. Do you have trouble falling asleep? _____
9. Do you nap during the day? _____
10. If so, how many times do you nap and for how long? _____
11. Do you drink alcohol, and if so how much? _____
12. Do you consume foods with caffeine (soft drinks, tea, coffee, chocolate? If so how much? _____
13. Do you use tobacco? If so, how much? _____
14. Do you feel there is undue stress in your life now? _____
15. Do you exercise close to bedtime or perform tasks requiring a lot of mental concentration before bedtime? _____
16. Do you snore? _____
17. Have you been told by a bed partner that you stop breathing during sleep? _____
18. Have you been told by a bed partner that you move your legs about or kick excessively during sleep? _____
19. Do you have cramping, pulling, or other disagreeable sensations in your legs when relaxing or trying to sleep?_____
20. Have you experienced any weakness in the legs during periods of excitement or stress? _____

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