Unity Sleep Disorders Center
Survey of Sleep

Name:____

DOB:___________________________Date:______________________

1. How many hours of sleep are you now getting in a typical night? ______ hours

2. How long does it take you to fall asleep once you are in bed? ______ minutes or ______ hours

3. Check off any of the following behaviors occurring during your sleep that either you or someone else has noted in the past year.

___Asthma
___Loud snoring
___Heart palpitations
___Waking up gasping or choking
___Waking up with heartburn
___Waking up with chest pain
___Waking up with frequent urge to urinate
___Rolling or rocking movement
___Shouting, screaming, or swearing
___Excessive sweating
___Walking in your sleep
___Talking in your sleep
___Bed-wetting
___Grinding your teeth
___Twitching of the legs or arms
___Large body jerks
___Restless sleep
___Falling out of bed
___Violent movements
___Frequent coughing

4. Do you feel drowsy or sleepy at any point during the day? ___Yes ___No

5. Do you ever have "sleep attacks" during the day (i.e. period when you cannot prevent yourself from falling asleep)? ____Yes ____No

6. Anything else significant related to your sleep?______________________________

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