Bristol Primary Care LLC
665 Terryville Ave
Bristol CT-06010

Sleep assessment (page 1 of 2)

Today's date:_____Date of birth: _____ Age: _____

First name:_____Last name: _____

Marital status:_____Current occupation: _____

Current weight:_____lbs. Weight five years ago: _____lbs.

Height:_____ Neck size: _____

Briefly describe your sleep problem: _____

_____

_____

List all prescription and over-the-counter medications you take: _____

_____

_____

List any allergies (include medications and food): _____

_____

_____

Have you had sleep studies done before? If yes, please list when and where: _____

_____

_____

What time do you usually go to bed? _____a.m./p.m.

What time do you usually get up?_____a.m./p.m.

How long does it usually take you to fall asleep? _____

On average, how many times do you wake up at night? _____

How many hours of sleep do you typically get each night? _____

Sleep assessment (page 2 of 2)

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Please answer following questions by circling yes or no.

1. Do you have times during the day when you want to nap? ..... Yes No
2. Do you take naps? ..... Yes No
3. Do you feel refreshed when you wake up in the morning? ..... Yes No
4. Have you been told that you snore or stop breathing while sleeping? ..... Yes No
5. Does your snoring disturb others? ..... Yes No
6. Do you talk or walk in your sleep? ..... Yes No
7. Do you snack or eat during the night? ..... Yes No
8. Do you sleep with a TV, audio player or light on? ..... Yes No
9. Do you have trouble falling sleep? ..... Yes No
10. Do you have trouble staying asleep? ..... Yes No
11. Do you feel worried or nervous about getting a good night's sleep? ..... Yes No
12. Do you notice creeping, crawling or aching feelings in your legs when in bed? And/or the inability to keep your legs still? ..... Yes No
13. Do you move around in your sleep? ..... Yes No
14. Do you dream often? ..... Yes No
15. Do you hardly ever dream? ..... Yes No
16. Have you ever experienced weakness in any part of your body during times of extreme laughter, sadness or excitement? ..... Yes No
17. What position do you like to go to sleep in? _____
18. What position are you in when you wake up? _____