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SPRINGHILL MEDICAL CENTER

PREVENTIVE CARE AND SLEEP MEDICINE

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NAME: _____ DATE: _____ AGE: _____

1. My usual bedtime is _____ P.M.
2. I usually take _____ minutes to fall asleep.
3. I wake up 1 2 3 4 or more times a night. (Circle a number)
4. My usual wake-up time is _____ A.M.
5. I usually take 0 1 2 or more naps during the day.
6. I am a shift worker ___Yes ___No

YES— PLEASE CHECK

NO— PLEASE LEAVE BLANK

7. ___ I have difficulty falling asleep.
8. ___ Thoughts race through my mind and this prevents me from sleeping at night.
9. ___ I wake up earlier in the morning than I would like.
10. ___ I have trouble concentrating at school/work.
11. ___ I have vivid nightmares.
12. ___ I've been told I "act out my dreams"
13. ___ I sleep walk/talk (___ occasionally ___ frequently)
14. ___ I have been told that I snore.
15. ___ I have been told that I stop breathing when I sleep.
16. ___ I feel sleepy during the day even though I slept through the night.
17. ___ During the night, I suddenly wake-up gasping.
18. ___ I have high blood pressure.
19. ___ I have been told that I am a restless sleeper & that I toss & turn at night.

20. ___ I sweat excessively during the night. (___ major ___ minor)
21. ___ I frequently awaken with headaches (___ major ___ minor)
22. ___ I am overweight or have gained weight. (___ lbs in last year.)
23. ___ I seem to be losing my sex drive.
24. ___ I have trouble concentrating or remembering things.
25. ___ I am hoarse in the morning.
26. ___ I wake up at night coughing and wheezing.
27. ___ I have frequent sore throats.

28. ___ I have trouble at school/work because of sleepiness.
29. ___ At times, no matter how hard I try to stay awake, I fall asleep anyway.
30. ___ I have fallen asleep while driving.
31. ___ I feel like I am going around in a daze.
32. ___ I feel like I have to cram a full day into every hour to get anything done.
33. ___ At times, I feel unable to move when I am waking up or falling asleep.
34. ___ I have experienced vivid dreamlike scenes upon falling asleep or awakening.
35. ___ I have fallen asleep when laughing or crying.
36. ___ When I am angry, surprised or laugh, I feel like I am going limp.

37. ___ I experience muscle tension in my legs even when I am otherwise relaxed; mostly in the evenings.
38. ___ I experience aching or "crawling" sensation in my leg(s); more at night.
39. ___ I experience leg pain during the night.
40. ___ At times, I can't keep my legs still at night. I feel like I have to move them.
41. ___ I have noticed or others have commented that parts of my body jerk while sleeping.
42. ___ I have been told that I kick at night.

- 43. ____ I wake up with heartburn.
- 44. ____ I have a chronic cough.
- 45. ____ I have to use antacids almost every week for stomach trouble.

On a scale of 1 thru 10 – 1 the least and 10 the most, Please rate the next questions.

- 46. I am an anxious person _____ (1thru 10)
- 47. I am a depressed person _____ (1-thru 10)
- 48. I have a chronic pain problem _____ (1-thru10)
- 49. My sleep difficulty is causing a lot of problems ____ (1 thru10)

STAFF TO COMPLETE:

Referring M.D. _____

Primary Care M.D. _____

HT: _____ **WT:** _____ **BMI:** _____ **BP:** _____

NS: _____ **ESS** _____ **FSS** _____

NOSE: _____ **Palatal Position** _____ **Lat. Wall** _____

Tonsils _____ **Retrognathia** _____

Dictation Confirmation # _____