



NEWPORT LONGEVITY MEDICAL GROUP, INC.

Insomnia Questionnaire *

Please complete if requested by the staff and bring to your next scheduled appointment or fax earlier to: (949) 721-9121.

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| 1. Do you experience difficulty falling asleep? | Yes | No |
| 2. Does your mind race when you are trying to go to sleep? | Yes | No |
| 3. Does it take you more than 20 minutes to fall asleep once the lights are off? | Yes | No |
| 4. Do you experience a "second wind" (increased energy) at night? | Yes | No |
| 5. Do you have difficulty staying asleep? | Yes | No |
| 6. Do you wake up more than once a night? | Yes | No |
| 7. Do you have difficulty getting back to sleep when awakened? | Yes | No |
| 8. Do you frequently awaken between 2:00-3:00 AM? | Yes | No |
| 9. Do you experience "restless legs" when trying to sleep? | Yes | No |
| 10. Do you recall your dreams? | Yes | No |
| 11. Do you sleep/nap during the day? | Yes | No |
| 12. Do you have vivid or disturbing nightmares? | Yes | No |
| 13. Do you feel groggy or sleepy when you wake up? | Yes | No |
| 14. Do you work the "third shift" (work nights/sleep days)? | Yes | No |
| 15. Are you depressed when the weather is overcast or cloudy? | Yes | No |
| 16. Are you taking any sleeping aids (natural or prescription)? | Yes | No |
| 17. Do you snore? | Yes | No |
| 18. Do you have, or have you ever been diagnosed with sleep apnea? | Yes | No |
| 19. Do you drink caffeinated drinks, or take stimulants/medications? | Yes | No |
| 20. Do you have children or pets that sleep in your room or bed? | Yes | No |
| 21. Do you exercise late in the day or at night? | Yes | No |
| 22. Do you eat carbohydrate snacks (cookies, ice cream, etc.) before bed? | Yes | No |
| 23. Do you eat anything between dinner and bedtime? | Yes | No |
| 24. Do you drink any alcohol at night? | Yes | No |
| 25. Do you have sinus problems, allergies, or asthma that gets worse at night? | Yes | No |
| 26. Does your sleep partner snore or keep you awake due to restlessness? | Yes | No |
| 27. Have you ever had a concussion or black out due to head trauma?
(females) | Yes | No |
| 28. Is your insomnia related to your menstrual cycle? | Yes | No |
| 29. Are you pre-, peri-, or post menopausal? | Yes | No |
| 30. Have you had a hysterectomy? | Yes | No |

*adapted from ARK