



Sleep History Questionnaire

Date: _____

Please answer the following questions to the best of your ability. We realize that some of this information is personal, and assure you that this information will be kept confidential. Only persons involved with your care will see this information. It may be helpful for you to ask your spouse, family member or significant other to help you complete this questionnaire. It is very important for you to answer the following questions as accurately and completely as possible. This information will be very helpful in identifying any sleep disorder(s) you may have.

- PLEASE PRINT CLEARLY -

<u>Patient Information:</u>	
Name: _____	Age: _____
Home Phone: _____	Date of Birth: _____
In Case Of Emergency Contact: _____	Phone: _____
Primary Care Physician: _____	Phone: _____
Referring Physician (if different): _____	Phone: _____

In the space below, please describe your main sleep problem(s) in your words. Include when and how this began, and what treatment you have received in the past for this problem.

What are your typical sleeping hours?

Bedtime Weekdays: _____ Rise time on weekdays: _____

Bedtime Weekends: _____ Rise time on weekends: _____

How many hours do you usually sleep per night? _____ Hours

How long does it usually take for you to fall asleep? _____ Minutes/Hours

Do you have difficulty falling OR staying asleep? If so, why? YES NO

How many times do you typically wake up at night? _____ Times

When you wake up at night, how long are you usually awake? _____ Minutes/Hours

Do you work split shifts or rotating (variable) shifts? YES NO

Do you take naps in the afternoon or evening? YES NO How long: _____

Please rate the following descriptions as they occur in your situation (check one category for each question):

	Never	Sometimes	Frequently	Constantly
a) Wake up at night short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Snore loudly enough that others complain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suddenly wake up from sleep, gasping for breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Observed by others having breathing problems during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Notice your heart beating strangely during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Fall asleep during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Fall asleep involuntarily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Fall asleep while driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Fall asleep during physical effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Fall asleep when laughing or crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Muscles become weak when extremely emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Have trouble at school or work due to sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Do in real life, what you are dreaming about (Have a dream about fighting someone, and punch the person next to you or the wall?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Walk in your sleep, talk in your sleep or eat in your sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Experience vivid dreams upon awakening or falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Have nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Observed to have leg or foot twitches during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Experience crawling and aching feelings in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Have morning jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Grind teeth during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIRECTIONS	SITUATIONS	CHANCE OF FALLING ASLEEP			
<p>How likely are you to fall asleep in certain situations? The following information can be helpful to your physician in diagnosing any sleep disorder you may have. Below is a list of different situations. Using the following scale, please indicate next to each situation how likely it would be for you to fall asleep. If you have not been in some of these situations lately, simply take a guess at how likely you would fall asleep. <u>Circle the appropriate number</u> to indicate how likely it would be that you would fall asleep.</p>		Would Never Fall Asleep	Slight Chance	Moderate Chance	High Chance
	Sitting and Reading	0	1	2	3
	Watching TV	0	1	2	3
	Sitting inactive in a public place (theater or meeting)	0	1	2	3
	Riding as a passenger in a car for more than 1 hour	0	1	2	3
	Lying down to rest in the afternoon when time permits	0	1	2	3
	Sitting and talking to someone	0	1	2	3
	Sitting quietly after lunch (without alcohol)	0	1	2	3
	In a car, while stopped for a few minutes in traffic	0	1	2	3

On average, how much of the following do you consume daily?

Do you use it in the evening? (6pm – 10 pm)

- | | | | | |
|----------------------------|-------|----------------|---|---|
| a. coffee (1 mug = 2 cups) | _____ | cups per day | Y | N |
| b. colas (caffeinated) | _____ | cans per day | Y | N |
| c. tea (caffeinated) | _____ | cups per day | Y | N |
| d. nicotine | _____ | packs per day | Y | N |
| e. alcohol | _____ | drinks per day | Y | N |

Please list all medications you are currently taking. *Please include prescription medications, over-the-counter medications (ex: aspirin, allergy), herbal formulas, vitamins, etc. – even if you only use them occasionally.* If you need additional space, please attach an additional paper.

	<u>NAME</u>	<u>AMOUNT</u>	<u>REASON</u>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____
f.	_____	_____	_____
g.	_____	_____	_____
h.	_____	_____	_____
i.	_____	_____	_____
j.	_____	_____	_____

MEDICAL HISTORY:

	Yes	No		Yes	No
High Blood Pressure	[]	[]	Diabetes	[]	[]
Emphysema/COPD	[]	[]	Atrial fibrillation	[]	[]
Heart Failure	[]	[]	Depression	[]	[]
Coronary Artery Disease	[]	[]	Anxiety	[]	[]

Additional medical problems (include approximate date of diagnosis)	Surgeries (include date)

FAMILY HISTORY:

Are there any members of your family with sleep disorders? If so, what is your relationship and what is their diagnosis?	Relative (i.e. mother, father)	Diagnosis

REVIEW OF SYSTEMS: Check any current or longstanding problems.

General: <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight loss ____# <input type="checkbox"/> Weight gain ____# <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unusual fatigue or loss of energy <input type="checkbox"/> Other _____	Gastrointestinal: <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____	Neurologic: <input type="checkbox"/> Trouble with walking or balance <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness and tingling <input type="checkbox"/> Difficulty with speech <input type="checkbox"/> Headaches <input type="checkbox"/> Decreased alertness <input type="checkbox"/> Other _____
Eyes: <input type="checkbox"/> Visual problems <input type="checkbox"/> Tearing <input type="checkbox"/> Drainage <input type="checkbox"/> Other _____	Musculoskeletal: <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Pain or swelling in joints <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Other _____	Psychiatric: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Other _____
Ears, Nose, Mouth, Throat: <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Pain or pressure in ears <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Other _____	Genitourinary: <input type="checkbox"/> Burning with urination <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Other _____	Endocrine: <input type="checkbox"/> Hotter or colder than others <input type="checkbox"/> Flushing <input type="checkbox"/> Other _____
Cardiovascular: <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Pain in legs when walking <input type="checkbox"/> Other _____	Hematology/Lymphatic: <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> Swollen glands <input type="checkbox"/> Other _____	Allergic/Immunologic: <input type="checkbox"/> Food allergies _____ <input type="checkbox"/> Drug allergies _____ <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Frequent infections <input type="checkbox"/> Other _____
		Skin: <input type="checkbox"/> Rashes <input type="checkbox"/> Change in color of mole <input type="checkbox"/> Other _____

SOCIAL HISTORY:

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Number of children	_____			
Current occupation	_____	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disabled
Former occupation(s)	_____			
Leisure activities	_____			