Sleep History Questionnaire

Name: ____________________________________________  Date: ___________________
Birthdate: ___________________  Age: ________  Occupation: ________________________
Sex: ______________Height: _________  Weight: ________  Weight Last Year: __________
Referring Doctor: ______________________  Family Doctor: __________________________
===================================================================== 
Describe your sleep problem: _____________________________________________________
______________________________________________________________________________
What results do you expect: ______________________________________________________
______________________________________________________________________________

A. MEDICATION SURVEY
Please list all PRESCRIPTION and NON-PRESCRIPTION medications you’re currently taking.

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ALLERGIES: _________________________________________________________________

B. PLEASE LIST ALL PAST OR PRESENT MEDICAL CONDITIONS OR SURGERIES

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C. SLEEP PATTERN
1. Circle the days of the week you work:
   Monday    Tuesday    Wednesday    Thursday    Friday    Saturday    Sunday
2. ON WORKDAYS
   a. What time do you go to bed: __________________________
   b. What time do you get out of bed: __________________________
3. ON WEEKENDS & HOLIDAYS
   a. What time do you go to bed: __________________________
   b. What time do you get out of bed: __________________________
4. How long does it take for you to fall asleep? __________________________
5. How many times a night do you awaken?
   a. How long do the awakenings last? __________________________
   b. List any symptoms associated with the awakenings: __________________________
6. SLEEP TIME
   a. How many hours do you usually sleep? (do not include hours spent in bed awake) __________________________
   b. How many hours does it take to make you feel rested? __________________________
   c. How many daytime naps do you take per week? __________________________
7. SLEEP QUALITY
   a. Do you feel unrefreshed and still sleepy upon awakening? YES NO
   b. How long does it take to fully awaken in the morning? __________________________
8. In the daytime, are you chronically sleepy, fatigued or tired? YES NO
9. Grade your tendency to FALL ASLEEP during the following situations: (0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

   a. Sitting and reading
   b. Watching TV
   c. Sitting inactive in a public place (e.g. theater or meeting)
   d. As a passenger in a car for an hour without a break
   e. Lying down to rest in the afternoon
   f. Sitting and talking to someone
   g. Sitting quietly after lunch without alcohol
   h. In a car, while stopped for a few minutes

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**D. SLEEP AND BREATHING**

1. Do you snore? **YES**  **NO**
2. Is your snoring broken by hesitations, gasps and snorts? **YES**  **NO**
3. Are the hesitations long enough to frighten your sleep partner? **YES**  **NO**
4. Has your snoring driven your bed partner from the bedroom? **YES**  **NO**
5. Do you awaken with a dry mouth? **YES**  **NO**
6. Do you awaken with headaches? **YES**  **NO**

**E. INSOMNIA**

1. Do you have trouble falling or staying asleep? **YES**  **NO**
2. Do you worry about being able to fall asleep on time? **YES**  **NO**
3. Do you feel sleepy prior to getting into bed? **YES**  **NO**
4. Does your mind race with thoughts when lying awake? **YES**  **NO**
5. Do daytime worries keep you awake at night? **YES**  **NO**
6. Does pain disturb your sleep? **YES**  **NO**
7. Does heat, cold, hunger or thirst disturb your sleep? **YES**  **NO**
8. Is your insomnia the primary reason your life is in disarray? **YES**  **NO**
9. Do you rely on a sleeping medication? **YES**  **NO**
10. Do you watch TV, read, or work in bed? **YES**  **NO**
11. Do you frequently travel across 2 or more time zones? **YES**  **NO**

**F. SLEEP DISTURBANCES**

1. Do you experience unpleasant leg sensations at bedtime? **YES**  **NO**
2. Do you kick or jerk your legs and/or arms during sleep? **YES**  **NO**
3. Do you have sweats or awaken from sleep feeling flushed? **YES**  **NO**
4. Do you awaken with a bitter or acid taste? **YES**  **NO**
5. Do you frequently have nightmares or vivid dreams? **YES**  **NO**
6. Do you grind your teeth or have bitten your cheek during sleep? **YES**  **NO**
7. Have you ever walked or talked in your sleep? **YES**  **NO**
8. Have you ever been unable to move for a few moments after awakening? **YES**  **NO**
9. Have you ever seen or felt things from your dreams after awakening? **YES**  **NO**
10. Have you ever experienced weakness when laughing or angry? **YES**  **NO**
11. Have you ever had unusual movements or behaviors during sleep? **YES**  **NO**

Describe: ________________________________

**G. PERSONAL HABITS**

1. Do you use tobacco now or have you in the past? **YES**  **NO**
   a. If yes, how many per day and for how many years? _____________________________
   b. If yes, what time of day is your last use? ________________________________
2. Do you drink alcohol? **YES**  **NO**
   a. If yes, how many drinks? ______ per day / per week / per month (circle one).
   b. If yes, what time of day is your last drink? ________________________________
3. How many caffeinated beverages do you drink per day? ____________________
   a. If yes, what time of day is your last drink? ________________________________
H. FAMILY HISTORY

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(continue below if necessary)

1. List any relatives who have sleep problems or snore?

_________________________________            _______________________________
_________________________________            __________________________________

I. PERSONAL HISTORY (Check any and all that apply)

- skipped heart beats
- high blood pressure
- epilepsy
- nasal congestion
- asthma

- heart failure
- thyroid problems
- headaches
- deviated nasal septum
- glaucoma

- heart attack
- diabetes
- emphysema
- enlarged tonsils
- depression/anxiety

- heart murmur
- stroke
- sinusitis
- allergies
- Bipolar disorder

J. BED PARTNER QUESTIONNAIRE (Please have your bed partner check any and all that apply)

- Light snoring
- Heavy snoring
- Pauses in breathing
- Snoring
- Teeth grinding

- Sleep walking
- Sleep talking
- Bed-wetting
- Head rocking/banging
- A shaking fit

- Leg or body twitching
- Leg jerking
- Daytime sleepiness
- Daytime confusion
- Depression/anxiety

1. Provide additional detail regarding any of the above. Please describe the activity, the time it occurs, and how often it occurs.

K. ADDITIONAL INFORMATION