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Sleep History Questionnaire

B/P____/_____
Pulse:_____
Neck Circum_____
Wgt:_____
Pulse Ox_____

Name:_____ Date:_____

Primary Physician:_____

Referring Physician:_____

If no Referring Physician, how did you hear about us?

Current Medications	Dosage and Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use supplemental oxygen? YES NO Amount:_____l/min

Medication Allergies:_____

_____

Height:_____ Weight: at present_____ 1 year ago_____ high school_____

For Doctor's Use:

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to think how you would react. Use the following scale to choose the **most appropriate number rating** for each situation.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

1. Sitting and reading _____
2. Watching TV _____
3. Sitting, inactive, in a public place _____
4. As a passenger in a car for an hour without a break _____
5. Lying down to rest in the afternoon when circumstances permit _____
6. Sitting and talking to someone _____
7. Sitting quietly after lunch _____
8. In a car, while stopped for a few minutes in traffic _____

Total _____

1. Have you been told that you snore? Yes No
2. If yes, was this while wearing PAP? Yes No N/A- I don't use PAP
3. Do you suffer from nasal allergies? Yes No
4. Have you had corrective nasal surgery? Yes No
5. Do you take any medications that cause you to suffer from dry mouth? Yes No
6. Do you sleep in a cool room? (less than 65 degrees) Yes No
7. Do you sleep with the windows open year round? Yes No
8. Do you feel like you have chronic nasal congestion issues? Yes No
9. Are you over the age of 60? Yes No

Today's Chief Complaint - answer all that apply

	Duration	
Excessively tired throughout the day	_____years	_____months
Gasping for air during the night	_____years	_____months
Snoring	_____years	_____months
Can't fall asleep at night	_____years	_____months
Can't stay asleep at night	_____years	_____months

Unusual behaviors during sleep Please explain _____
Other _____

Sleep Patterns/Environment

	Weekdays	**Weekends**
Typical bedtime	_____	_____
Amount of time to fall asleep	_____	_____
Time up in the morning	_____	_____
Average # of hours slept	_____	_____
Average # of awakenings per night	_____	_____
Number of bathroom trips	_____	_____
Number of naps	_____	_____

Sleep disturbances - circle all that apply

Pain Anxiety Spouse Snoring Pets Children

Breathing Coughing Worrying Other:_____

Do you have aching or restlessness in your legs at night with an urge to move them? YES NO

Number of nights per week you are using alcohol before bed:_____

Do you currently use a sleep aid? YES NO name:_____

Do you awake in the morning feeling refreshed? YES NO

Any history of accidents (work or car) due to sleepiness? YES NO
Please describe if YES: _____

Past Sleep Evaluation and Treatment - answer all that apply
If this is your first evaluation skip to next section

My last sleep evaluation was:
_____less than 6 months ago _____less than 1 year ago _____ years ago

Where:_____
It included: Overnight Sleep Study Daytime Naps

I was diagnosed with:_____

I use a CPAP or Bi-Level Machine YES NO
if yes, what is your pressure setting? _____ cm/H2O

I have had surgery to treat a sleep disorder YES NO
if yes, what type of surgery was performed? _____

I have been prescribed medication to treat a sleep disorder YES NO
list medication:_____

Past Medical History - please circle all that apply

High Blood Pressure	Stroke	Diabetes	Depression	Anxiety
Asthma/Emphysema	Reflux	Seizures	Heart Disease	Cancer
Parkinson's Disease	Fibromyalgia	Lung conditions	Thyroid Conditions	
Head Injury	Hearing Impairment			

List any other medical problems that may disrupt your sleep:

_____

List any surgeries and the year performed:

_____

Approximate date of last influenza vaccine:_____

If you are age 65 or older, approximate date of last pneumococcal vaccine: _____

Social History

Marriage Status: Married Single Divorced Widowed

Sleep Arrangements: Sleep alone Share bed Separate Beds

Occupation:_____ Employed Unemployed Retired Student

Do you smoke? YES NO Are you a former smoker? YES NO

Cigarettes/Cigars/Tobacco _____ packs/day for _____years

Year quit _____ Packs/day_____ for _____ years

Do you drink alcohol? YES NO

Amount:_____ Type of alcohol:_____

Frequency: Daily Weekends Occasionally

Caffeine? YES NO Amount:_____ cups _____ cans per day

Family History - please circle all that apply

Mother apnea snoring narcolepsy insomnia other:_____

Father apnea snoring narcolepsy insomnia other:_____

Sister(s) apnea snoring narcolepsy insomnia other:_____

Brother(s) apnea snoring narcolepsy insomnia other:_____

Other_____

1. I have trouble falling asleep.	Never	Sometimes	Always
2. I have trouble staying asleep.	Never	Sometimes	Always
3. I read or watch TV in bed before falling asleep.	Never	Sometimes	Always
4. I often wake up during the night.	Never	Sometimes	Always
5. At bedtime, thoughts race through my mind.	Never	Sometimes	Always
6. I smoke less than 2 hours before going to bed.	Never	Sometimes	Always
7. I eat a snack at bedtime.	Never	Sometimes	Always
8. If I wake up at night I eat a snack.	Never	Sometimes	Always
9. I have nightmares.	Never	Sometimes	Always
10. I sweat a lot during the night.	Never	Sometimes	Always
11. I kick my legs and/or arms during the night.	Never	Sometimes	Always
12. I walk in my sleep.	Never	Sometimes	Always
13. I talk in my sleep.	Never	Sometimes	Always
14. I grind my teeth while I sleep.	Never	Sometimes	Always
15. I wake up at night choking or gasping for air.	Never	Sometimes	Always
16. I wake my self up with my snoring.	Never	Sometimes	Always
17. I have been told I snore while lying on my back.	Never	Sometimes	Always
18. I feel my heart pounding at night.	Never	Sometimes	Always
19. At bedtime I feel sad or depressed.	Never	Sometimes	Always
20. I feel unable to move (paralyzed) after a nap.	Never	Sometimes	Always
21. I have dream like images when I wake up even though I know I am not asleep.	Never	Sometimes	Always
22. I have experienced sudden muscle weakness in response to emotions such as laughter or surprise.	Never	Sometimes	Always
23. I take a nap(s) on a regular basis.	Never	Sometimes	Always
24. I have fallen asleep while driving.	Never	Sometimes	Always
25. I get “stuffed up” while sleeping.	Never	Sometimes	Always
26. My breathing is worse when I sleep on my back.	Never	Sometimes	Always
27. I get morning headaches.	Never	Sometimes	Always
28. I wake up with a dry mouth.	Never	Sometimes	Always
29. Pain wakes me up at night.	Never	Sometimes	Always
30. I wet the bed.	Never	Sometimes	Always
31. I wake up due to heartburn, reflux, a sour stomach, or burping.	Never	Sometimes	Always

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Emergency Contact Name and relationship _____
(**Someone that does not live with you**)

Address _____

City _____

State _____

Zip Code _____

Phone number _____