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)

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   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
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

AGE

MEDICAL CONDITIONS

Father: ______

Mother: ______

Sibling 1: ______

Sibling 2: ______

Sibling 3: ______

(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  heart failure  heart attack  heart murmur

high blood pressure  thyroid problems  diabetes  stroke

epilepsy  headaches  emphysema  sinusitis

nasal congestion  deviated nasal septum  enlarged tonsils  allergies

asthma  glaucoma  depression/anxiety  Bipolar disorder

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

Light snoring  Sleep walking  Leg or body twitching

Heavy snoring  Sleep talking  Leg jerking

Pauses in breathing  Bed-wetting  Daytime sleepiness

Snorting  Head rocking/banging  Daytime confusion

Teeth grinding  A shaking fit  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