



## Sleep History Questionnaire

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth date \_\_\_\_\_ Gender: Male/Female Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Referring physician or primary care doctor \_\_\_\_\_

Please describe the trouble you are having with your sleep:

---

---

---

---

---

---

---

---

*If you feel it is necessary, please explain your yes answers.*

### **Sleep**

Do you snore?       No     Yes

Have you been told that you stop breathing or struggle to breathe during your sleep?

No     Yes

Do you feel sleepy in the daytime?     No     Yes

If yes, how sleepy?    Mildly                  Moderately                  Severely

Have you had driving accidents or near accidents due to sleepiness?     No     Yes

What is your usual bedtime?    Work days \_\_\_\_\_ Days off \_\_\_\_\_

What time do you awaken?    Work days \_\_\_\_\_ Days off \_\_\_\_\_

Do you work an unusual schedule (swing shift, late night to early morning or similar)?

If yes, what are your usual work hours?    Start \_\_\_\_\_                  End \_\_\_\_\_

Do you usually sleep somewhere besides a bed (for example in a chair)?     No     Yes

If yes, where and why? \_\_\_\_\_

Do you nap in the daytime?     No     Yes

If yes, how often? \_\_\_\_\_

If yes, for how long usually? \_\_\_\_\_

How many times do you awaken on an average night?

Never      1-2 times      2-3 times      3 or more times

Why? Don't know    Need to urinate      For a snack    Racing thoughts      Pain

Disturbance in the bedroom (spouse, pet, child)

Other, (please explain) \_\_\_\_\_

Do you have insomnia?       No     Yes

If yes, how long has this been a problem? \_\_\_\_\_

Have you tried any medications to help you sleep? \_\_\_\_\_

Is your bedroom quiet?       No     Yes

Is your bedroom dark?       No     Yes

When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that is relieved only by walking or movement?       No     Yes

If yes, how often? \_\_\_\_\_

Do you ever awake feeling totally paralyzed?       No     Yes

Do you have waking dreams or hallucinations shortly before or after sleep?       No     Yes

While awake, do you ever lose muscle strength when you laugh or are stressed?  No     Yes

Have you ever had a seizure at night?       No     Yes

Do you usually wake up with a headache?       No     Yes

### **Weight**

Have you gained or lost more than about 10 lbs in the last 1 – 2 years?       No     Yes

### **Family History**

Does any one in your family have sleep apnea?       No     Yes

Does anyone in your family have narcolepsy?       No     Yes

### **Medical Issues**

Do you have high blood pressure or are you currently taking high blood pressure medication?

No     Yes

Have you had congestive heart failure, heart attack or stents placed in the heart?       No     Yes

Do you have lung problems such as asthma or emphysema?       No     Yes

Do you take medications for pain?       No     Yes

Do you have diabetes?       No     Yes

Have you had a stroke?       No     Yes

Do you have any other neurological problems?       No     Yes

Do you have a history of acid indigestion (GERD)? (GERD)       No     Yes

Do you have a history of depression/ anxiety?  No  Yes

Do you have any other medical problems?  No  Yes

If yes, please explain

---

---

---

### **Surgeries**

Have you had your tonsils removed? \_\_\_\_\_  No  Yes

Have you had nose/throat surgery? \_\_\_\_\_  No  Yes

Please list any other surgeries or operations you have had?

---

---

---

### **Medications**

Please list your medicines, including over the counter medicines and vitamins or herbs.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How likely are you to “doze off” or fall asleep in the situations described below?

Use the following scale to select the number that fits you best.

0 – I would never doze of

1 - There is a slight chance I would doze off

2 – There is a moderate chance I would doze off

3 – There is a high chance I would doze off

\_\_\_\_\_ Sitting and reading

\_\_\_\_\_ Watching television

\_\_\_\_\_ Sitting inactive in a public place like a meeting or classroom

\_\_\_\_\_ As a passenger in a car for one hour

\_\_\_\_\_ Lying down to rest in the afternoon

\_\_\_\_\_ Sitting and speaking to someone

\_\_\_\_\_ Sitting quietly after lunch (without alcohol)

\_\_\_\_\_ Driving in a car while stopped for a few minutes in traffic