SLEEP HISTORY / QUESTIONNAIRE

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Date:_____ Name _____ SS#_____

Ht._____ Wt._____Age_____Occupation_____

It is important for you to be as accurate as possible in answering the following questions.
The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions **as thoroughly as you can.**

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE

1. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

   _____

   _____

   _____

2. How often does this problem occur?
   ( ) almost every night
   ( ) for periods of at least one week
   ( ) irregularly
   ( ) other_____

3. How long has this problem bothered you?
   ( ) longer than 2 years
   ( ) 1 to 2 years
   ( ) several months
   ( ) within the last 3 months
   ( ) within the last month

4. How do you describe your sleep problem? Check all that apply to you.
   ( ) difficulty falling asleep
   ( ) wake up during the night
   ( ) wake up early in the morning'
   ( ) 1 xcessive daytime sleepiness
   ( ) difficulty awakening

5. Do any other members of your family have sleep problems? Please explain:

6. Have you had a weight change in the past 6 months?_____

7. How much have you gained_____ or lost _____ ?

8. How many hours of sleep do you usually get per night?

9. What time do you usually go to bed on WEEKDAYS?_____WEEKENDS?_____

10. What time do you usually awaken in the morning on WEEKDAYS?_____WEEKENDS?_____

11. Are your sleep habits on weekends different from the rest of the week?
( ) No
( ) Yes - please describe_____

12. How long does it take for you to fall asleep?_____

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

14. If you wake up, on the average, how long do you stay awake?_____

15. If you do awaken during the night (after you fall asleep) which part (s) of your sleep period is it?

_____

16 What do you usually do when you awaken during the night?_____

17. Is your sleep disturbed by:
( ) heat ( ) light ( ) need to eat
( ) cold ( ) bed partner
( ) noise ( ) not being in your usual bed
( ) bathroom ( ) need to smoke cigarettes
( ) other _____

18. Do you usually : (check all that apply to you)
( ) sleep with someone else in your bed
( ) sleep with someone else in your room
( ) provide assistance to someone during the night (child, invalid, bed partner, animal)

19. On the average, how long do you stay in bed after waking up in the morning?_____

20. Do you work split shifts or rotating (variable) shifts? _____

21. Do you:

Feel afraid of going to sleep? Yes____ No____

Notice that parts of your body jerk or kick during the night? Yes____ No____

Experience crawling and aching feelings in your legs? Yes____ No____

Experience any type of leg pain during the night, including cramps? Yes____ No____

Continued

Do you:

Usually drink coffee or tea within 2 hours before you go to bed?	Yes___No___
Do physical exercise before bedtime?	Yes___No___
Read before falling asleep?	Yes___No___
Watch TV in bed before falling asleep?	Yes___No___
Awaken from sleep short of breath?	Yes___No___
Awaken at night with heartburn, belching or coughing?	Yes___No___
Notice your heart pounding or beating irregularly during the night?	Yes___No___
Have morning jaw pain?	Yes___No___
Grind your teeth during sleep?	Yes___No___
Awaken with pain during the night?	Yes___No___
Snore loudly enough that others complain?	Yes___No___
Have periods where you stop breathing during sleep (observed by others)?	Yes___No___
Act out your dreams?	Yes___No___
Sleep walk?	Yes___No___
Sleep talk?	Yes___No___
Fall asleep during the day?	Yes___No___
Fall asleep involuntarily?	Yes___No___
Fall asleep while driving?	Yes___No___
Take naps during the afternoon or evening?	Yes___No___
Have trouble at school or work because of sleepiness?	Yes___No___
Fall asleep during physical effort, laughing or crying?	Yes___No___
Experience loss of muscle tone when extremely emotional?	Yes___No___
Feel unable to move (paralyzed) when waking or falling asleep?	Yes___No___
Have nightmares or experience vivid dreamlike scenes upon awakening or falling asleep?	Yes___No___
Feel sad, depressed, anxious or tense?	Yes___No___

How likely are you to dose off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you.. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing
3 = high chance of dozing

Situation:

- sitting and reading _____
- watching TV _____
- sitting, inactive in a public place (ex. theatre or meeting) _____
- as a passenger in a car for an hour without a break _____
- lying down to rest in the afternoon when circumstances permit _____
- sitting and talking with someone _____
- sitting quietly after lunch without alcohol _____
- in a car, while stopped for a few minutes in traffic _____

Past Medical History

Have you ever been diagnosed personally with any of the following illnesses or conditions?

	YES	NO	YEAR DIAGNOSED
Asthma	_____	_____	_____
Pneumonia	_____	_____	_____
Bronchitis	_____	_____	_____
Emphysema, COPD	_____	_____	_____
Tuberculosis (TB)	_____	_____	_____
Pulmonary Fibrosis	_____	_____	_____
Phlebitis (clot in vein)	_____	_____	_____
Pulmonary Embolus (clot traveled to lung)	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Failure	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Diabetes	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____

Specify type:_____

Glaucoma	_____	_____	_____
Stomach ulcers / Heartburn	_____	_____	_____
Diverticulitis	_____	_____	_____
Hepatitis / liver disease	_____	_____	_____
Pancreatitis	_____	_____	_____
Gall bladder stones / infection	_____	_____	_____
Kidney stones / infection	_____	_____	_____
Gout	_____	_____	_____
Arthritis	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Fibromyalgia	_____	_____	_____

Do you take any kind of medication?

Name	Amount	How Often	Reason

Do you have any drug allergies? If so, what drugs?

_____

Surgical History

Please list any operations and the years you had them:

_____

_____

Family Health History

	Age	Medical Condition
Father	_____	_____
Mother	_____	_____
Brother (s)	_____	_____
Sister (s)	_____	_____
Children	_____	_____

Social History

Are you: Married_____ Single_____ Divorced_____ Widowed_____

List your consumption of the following per day:

Cigarettes	Yes_____	Packs/Day_____	Never_____	Used to_____	Months/Years Ago____
Caffeine	Yes_____	No_____	Quantity (Beverages/Day)_____		
Alcohol	Yes_____	No_____	Quantity (Beverages/Day)_____		
Recreational Drugs	Yes_____	No_____			

Review of Systems

Mental Health:_____
(for example: depression, thoughts of suicide, alcoholism)

Nervous System: _____
(for example: strokes, seizures, diabetic nerve damage, history of concussion, loss of consciousness)

Ears, Eyes, Nose, Throat: _____
(for example: asthma allergies, polyps or tumors)

Breathing: _____
(for example: asthma, bronchitis, emphysema)

Stomach: _____
(for example: swallowing difficulties, heartburn, indigestion, hiatal hernia, ulcers)

Bowels: _____
(for example: diarrhea, constipation, cancer)

Urinary or Kidney: _____
(for example: infection with frequent nighttime urination or diuretics, stones, cancer)

Hormones: _____
(for example: high or low thyroid conditions, prescribed steroids such as prednisone or estrogen for menopause)

Blood: _____
(for example: "low blood" or anemia, thick blood, sickle cell disease, or HIV infection)

Chronic pain: _____
(for example: arthritis, broken hip, osteoporosis, fibromyalgia)