



Patient History & Sleep Questionnaire

Patient Full Name: _____ Nick Name: _____

Birth date: _____ Age: _____ Sex: _____

Height: _____ Current Weight: _____ Weight Five Years Ago: _____ Peak Lifetime Weight: _____

Marital Status: Single Married Divorced Widowed Separated

Employer: _____ Occupation: _____

PATIENT PROBLEM:

Briefly describe the problem with your sleep as you see it:

PATIENT EXPECTATION:

What is the nature of assistance you expect or desire?

Patient History

Yes No Have you been evaluated at a Sleep Disorders Center Before?

If yes, when (date) _____ where _____

What were you told the problem was? _____

What treatment were you given? _____

Why are you being evaluated again? _____

Tobacco

- Yes No Have you ever smoked tobacco?
- Yes No Do you currently smoke tobacco? How much per day? _____ How long have you smoked? _____
- Yes No If you smoke tobacco, do you smoke when you wakeup during the night?
- Yes No If you smoke tobacco, have you noticed that nicotine alters or interferes with your sleep?

Beverages

- Yes No Do you usually drink coffee, tea, chocolate, cola or other caffeinated beverages within 2 hours of your bedtime?

How much of the following do you have in a usual day?

Coffee/Tea _____ Cola _____ Chocolate _____ Other _____

- Yes No Do you drink alcoholic beverages?

Assuming the following drinks are equivalent: 12oz beer, 5oz wine, 3oz port, and 1.5oz whiskey, gin or vodka, then:

How many drinks do you have in a usual weekday? _____ On a weekend or holiday? _____

- Yes No Do you drink alcohol within two hours of bedtime?
- Yes No Do alcoholic beverages alter or interfere with your sleep?
- Yes No Have you ever used alcohol in order to get to sleep?
- Yes No Have you ever sought treatment/counseling for an alcohol problem?

Have you ever had the following problems in association with drinking alcoholic beverages?

- Yes No Blackouts
- Yes No Violent or over excited behavior
- Yes No Automatic behavior (carrying on unaware of your actions)
- Yes No D.T.'s, shakes, hallucinations
- Yes No Arrests for drunken driving
- Yes No Family complaints about your drinking
- Yes No Personal concern about your drinking
- Yes No Late or missed work or appointments
- Yes No Detoxification or other treatment

Exercise

- Yes No Do you exercise on a regular basis? If yes, how many times per week? _____
- What time of day do you usually exercise? _____

General

- Yes No Do you have Diabetes? If yes, what type? _____
- Yes No Have you recently had any unexplained weight loss?

Yes No Have you noticed being unusually thirsty?

Sleep Questionnaire

Sleep Hygiene

How many hours of sleep do you get in a typical night? _____

Yes No Do you go to bed at the same time each night?

If yes, what is your bedtime? _____

Yes No Do you get up the same time each morning?

If yes, what is your rise time? _____

Yes No Do you feel like you get enough sleep at night?

Yes No Does your sleep schedule change by more than 2 hours on the weekends?

Yes No Do you read or watch TV in bed?

Yes No Are you a shift worker?

If yes what is your usual shift and schedule: _____

Sleep Environment

Yes No Do you have a quiet, peaceful place to sleep?

Yes No Is your sleep disturbed because of noise, heat, cold, lights or pets?

If yes, what are the disturbances? _____

Yes No Do you have any children under two living with you?

Excessive Daytime Sleepiness

Yes No Do you snore?

Yes No Do you or your bed partner believe that you move your arms or legs to much when you sleep?

Yes No Do you take naps during the day?

Yes No Do you wake up in the morning with a dry mouth?

Yes No Do you wake up in the morning with a headache?

Yes No Do you have many night sweats?

Yes No Has a bed partner ever witnessed you stopping breathing when you sleep?

Yes No Have you ever had a traffic accident due to drowsy driving?

Yes No Has a bed partner ever heard you gasping at night when you sleep?

Yes No Do you find it almost impossible to remain awake in a lecture, at your desk or in a meeting?

Yes No Do you wake up at night with your heart racing or in a panic?

Yes No Do you feel that your personality has changed due to sleepiness?

Insomnia

- Yes No Do you have a hard time falling asleep?
How long does it take you to fall asleep usually? _____
- Yes No Do you fall asleep, but then wake up for no reason and can't fall back to sleep?
- Yes No Do you feel that there are significant stresses in your life right now?
- Yes No Are you afraid of going to sleep?
- Yes No Do you watch TV, read or do paperwork in bed?
- Yes No If you are unable to sleep, do you get out of bed?
If yes, what do you do? _____
- Yes No Is it easier to fall asleep in another room or on the sofa or easy chair?
-

Limb Movements

- Yes No Do your legs have a twitching, tingling or burning sensation when you are trying to go to sleep?
- Yes No If yes, do you get up and walk around to relieve these symptoms?
- Yes No Does your bed partner complain about you kicking your legs or arms at night?
- Yes No Are you bothered by leg cramps or pains in the calf (charley horses) during the night?
- Yes No Do you have any other type of pain during the day or night?
If yes, briefly explain: _____
-

Neurology

- Yes No Do you have vivid dreams shortly after falling asleep at night?
- Yes No Do you have hallucinations or dream-like mental images when you are falling asleep or as you wake up?
- Yes No Have you ever felt paralyzed or unable to move when falling asleep at night?
- Yes No Have you ever felt paralyzed or unable to move when waking in the morning?
- Yes No Have you ever had attacks of sudden physical weakness or paralysis during the day, when laughing, angry or in other emotional situations?
If yes, how often does this happen? _____
- Yes No Do you ever have unexplained sleep episodes?
- Yes No Are your dreams so vivid that sometimes you confuse them with reality?
- Yes No Have you ever had a head injury?
If yes, explain: _____
- Yes No Have you ever been told that you bang your head or make rolling or rocking movements in bed at night?
- Yes No Have you been told you grind your teeth or do you know you do?

Dreaming & Sleep

Yes No Do you move while dreaming; as if attempting to carry out the dream?

Yes No Have you accidentally hurt yourself or bed partner during sleep, from arm flailing, leg jerking, falling out of bed or running into furniture?

Yes No Do you wake up from a dream in unusual places or doing unusual tasks?

If yes, please describe: _____

Epworth Sleep Scale

How likely are you to “doze off” or fall asleep in the situations described below? Using the following scale, select the number that is most appropriate for you.

- 0 - I would never doze off.
- 1 - There is a slight chance I would doze.
- 2 - There is a moderate chance I would doze.
- 3 - There is a high chance I would doze.

Write the number in the space after each situation:

Situations:

Sitting and reading_____

Watching television_____

Sitting inactive in a public place like a meeting or a 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)_____

In a car while stopped for a few minutes in traffic_____

1. Complete the following:

Has your weight changed?
Increased
Decreased
No change

2. Do you snore?

Yes No Don't know

If you snore:

3. Your snoring is...

Slightly louder than breathing
As loud as talking
Louder than talking
Very loud

4. How often do you snore?

Almost every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or almost never

5. Does your snoring bother other people?

Yes No

6. Has anyone noticed that you quit breathing during your sleep?

Almost every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or almost never

7. Are you tired after sleeping?

Almost every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or almost never

8. Are you tired during waketime?

Almost every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or almost never

9. Have you ever nodded off or fallen asleep while driving?

Yes No Don't know

If yes, how often does it occur?

Every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or almost never

10. Do you have high blood pressure?

Yes No Don't know

Spouse or Roommate Questionnaire

Check any of the following behaviors that you have observed the patient doing.

While Asleep

- Loud snoring
- Light snoring
- Twitching of legs or feet
- Pauses in breathing
- Sleep talking
- Sleep walking
- Bed wetting
- Sitting up in bed not awake
- Kicking of the legs
- Getting out of bed not awake

While Awake

- Depression
- Change in personality
- Loss of intellectual function
- Excessive daytime sleepiness
- Weight gain
- Grinding teeth
- Fatigue
- Morning headache
- Irritability

How long have you been aware of the sleep behaviors that you checked above?

Describe the sleep behaviors described above in more detail. Including the type of activity, the time of night in which it occurs, frequency during the night and whether it occurs every night.

If you have described loud snoring, do you remember hearing short pauses in the snoring or occasional loud snorts?