SLEEP MEDICINE

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SLEEP HISTORY QUESTIONNAIRE

DATE:_____

Patient Name: _____ Date of Birth: _____ Age:_____
Who referred you to the sleep center:_____
Who is your primary care physician:_____
Height : _____ Your weight:_____ Male_____Female_____
Occupation: _____
Please describe in your own words your sleep problems._____
_____
_____
_____
Duration you have had these problems?_____ Have you ever had a sleep study before? Yes___ No___
If so, where, when, and diagnosis?_____

Are you frequently fatigued or drowsy during the day? Yes___ No___
Have you ever had an accident or near accident due to drowsiness? Yes___ No___
Which position do you spend most of the night sleeping in?_____
Has anyone told you that you snore loudly? Yes___ No___
Do you snore in all sleeping positions? (Side, back) Yes___ No___
Do you snore continuously all night every night? Yes___ No___
Do you awaken with a dry mouth? Yes___ No___
Has anyone told you that you quit breathing during the night? Yes___ No___
Have you ever awakened gasping for breath? Yes___ No___
Do you have morning headaches? Yes___ No___
Do you sweat excessively at night? Yes___ No___

Do you awaken with a sour taste in your mouth? Yes___ No___
Do you ever awaken with a burning sensation in your chest? Yes___ No___
Do you have sudden episodes of sleep during the day? Yes___ No___
Have you ever experienced a paralyzed feeling while going to sleep or waking up? Yes___ No___
Have you ever experienced hallucinations or dream like mental images while falling asleep or on awakening? Yes___ No___
Have you ever experienced sudden muscle weakness during strong emotions? (Such as your legs going limp during laughter or anger.) Yes___ No___

Did you ever have childhood sleep problems of any kind? Yes___ No___
If yes, please describe:_____

Do you frequently kick or jerk your legs at night? Yes___ No___
Do you have uncomfortable or unpleasant sensations in your legs at rest? Yes___ No___
Do your unpleasant leg sensations improve with movement? Yes___ No___

Do you have difficulty initiating sleep at night? Yes___ No___
Do you have difficulty staying asleep at night? Yes___ No___
Do you have pain that bothers you at night? Yes___ No___
Have you ever been told you act out your dreams? Yes___ No___
Do you sleep walk? Yes___ No___
Do you sleep talk? Yes___ No___
Do you have frequent nightmares? Yes___ No___
Has anyone told you that you scream or yell during sleep? Yes___ No___
Do you grind your teeth during sleep or wake with jaw pain? Yes___ No___
Do you wet the bed during sleep? Yes___ No___

Patient: _____ DOB: _____

Sleep Schedule

Time you go to bed on a weekday? _____ Wake-up on a weekday? _____
What time do you go to bed on the weekend? _____ Wake-up? _____
How long does it take you to fall asleep? _____
How many hours of sleep do you average per night? _____ Do you nap frequently? Yes___ No___
How many times do you wake up during the night? _____ Reasons why you wake up? _____
_____
_____
What is your normal working schedule? _____

Past Medical History

_____Head trauma	_____Rheumatic Fever	_____Diabetes (Sugar)	_____Liver Disease
_____Emphysema	_____Heart Palpitations	_____Thyroid	(Hepatitis)
_____Bronchitis	_____Heart murmur	_____Colitis	_____Arthritis
_____Kidney Stones	_____Asthma	_____Heart Failure	_____Anemia
_____Epilepsy	_____Pleurisy	_____Angina/Chest Pain	_____High Blood Pressure
_____Depression	_____Nervousness	_____Tuberculosis	_____Phlebitis/blood clot in lung
_____Stomach Ulcers	_____Stroke	_____Gall Stones	_____Cancer Type_____
_____Gout	_____Sinus Infection	_____Hay Fever/Allergies	_____Heart Arrhythmia
_____Gerd/Acid Reflux	_____Pneumonia	_____Heart attack	_____Heart disease
_____Fibromyalgia	_____Other _____		

_____Dentures ____Upper (full or partial?) ____ Lower (full or partial?)

Surgery/Hospitalizations:

Date: _____Tonsillectomy	Date: _____Gall Bladder Removed
Date: _____Appendectomy	Date: _____Reason: _____
Date: _____Hernia Repair	Date: _____Reason: _____
Date: _____Hysterectomy	Date: _____Reason: _____
Date: _____ Snoring/Sleep Apnea Surgery	

Social History

TOBACCO: Have you ever used tobacco? _____Yes _____No
Cigarettes _____ Cigars _____ Pipes _____ Smokeless tobacco (snuff) _____
If you smoke(d), how many years? _____, and on average how many packs a day? _____
Are you still smoking? _____ If not, when did you quit? _____
ALCOHOL: Beer _____ Liquor _____ Wine _____
Socially _____To excess on occasion _____ Daily _____ Previous/current alcohol addiction _____
Coffee_____ Tea_____ Soda_____ Caffinated Drinks: _____ Type: _____
How many cups/glasses? _____
Do you have a substance abuse problem? _____
Do you use street drugs? _____Yes _____No

Family History

	Family member		Family member
Diabetes	_____	Heart Disease	_____
Hypertension	_____	Stroke	_____
Obesity	_____	Depression	_____
Anxiety	_____	Mental illness	_____

Has anyone in your family ever been diagnosed with a sleep disorder? Yes_____ No_____
If yes please name the disorder and the family member. _____
_____

Patient: DOB:

Medications

Please list all current medications (May use back of form if needed)

Name of medication	Dosage	Name of medication	Dosage

Have you ever tried any sleep medications? Name of medicine(s)

Helpful? Side effects?

Are you on oxygen therapy? ____Yes _____No If yes, how much?

Are you allergic to any medications? Yes___ No___ If yes, what medications?

Side effects?

Review of System: Please mark all applicable problems: Write a description if needed.

GENERAL:
___Weight gain in the past year.
How much? _____
___Weight lost in the past year.
How much? _____
___Fever
___Chills
___Poor appetite

EYES:
___Decreased vision
___Double vision
___Pain in eyes

EARS, NOSE, &THROAT:
___Earaches
___Ringing in ears
___Loss of hearing
___Sinus problems
___Nose congested or runny
___Postnasal drainage or frequent throat clearing
___Recurrent sore throat
___Persistent hoarseness

PSYCHIATRIC:
___Depression
___Nervousness
___Memory problems
___Angry/Irritable
___Claustrophbia

HEART & VASCULAR:
___Rapid, irregular, or pounding heart (circle all that apply)
___Swelling in legs or ankles
___Waking up at night short of breath
___Need to sleep on more than 1 pillow

RESPIRATORY:
___Chest pain
___Wheezing
___Coughing up sputum
___Coughing up blood
___Shortness of breath at rest
___Shortness of breath walking up hills/steps

GASTRONTESTIONAL:
___Frequent heartburn
___Nausea
___Diarrhea
___Constipation
___Abdominal pain
___Blood in stool
___Difficulty swallowing
___Choking with food or drink

ENDOCRINE:
___Excessive thirst
___Excessive urination
___Unable to tolerate cold weather
___Hoarseness of voice
___Loss of body hair

GENITOURINARY:
___Blood in urine
___Frequent urination
___Difficulty starting or emptying bladder

MUSCULOSKELTAL:
___Painful joints
___Swollen or red joints
___Back pain
___Sore muscles

NEURO:
___Passing out/fainting
___Seizure Disorder
___Frequent or severe headaches
___Tingling in hand or feet
___Loss of feeling in hands or or feet
___Headaches

SKIN & BREAST:
Rash
___Skin Cancer

OTHER:

Additional Comments

Patient: _____ DOB: _____

Epworth Sleepiness Scale

How likely are you to doze off in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. If you have not done some of these activities in recent times try to work out how they would affect 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	Chance of dozing
Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place (theater 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 to someone	_____
Sitting quietly after lunch without alcohol	_____
Sitting in a car while stopped for a few minutes in traffic	_____
Total Score	_____

Bed Partner Questionnaire (If you have a bed partner please have them answer the questions below.)

How often do you observe this patient sleep? _____
Where do you sleep in relation to the patient? _____
Has this person fallen asleep during normal daytime activities? Yes___ No___
Has this person fallen asleep during dangerous situations? Yes___ No___
If yes please explain: _____

_____

_____

What behaviors have you observed in this person while he/she was asleep?

Light snoring?	Yes___ No___
Loud snoring?	Yes___ No___
Loud snorts?	Yes___ No ___
Choking?	Yes___ No___
Pauses in breathing?	Yes___ No___
Leg kicking?	Yes___ No___
Leg or arm movements?	Yes___ No___
Shaking or rocking?	Yes___ No___
Screaming?	Yes___ No___
Sleep walking or talking?	Yes___ No ___
Teeth grinding?	Yes___ No ___
Bedwetting?	Yes___ No___

Please explain yes answers and list any other sleep behavior you have witnessed in this person.

_____

_____