



PATIENT SLEEP HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Referring Physician: _____ Height: _____

Age: _____ Gender: M / F Weight: _____

Have you had a recent weight gain? ___ No ___ Yes

Have you had a recent weight loss? ___ No ___ Yes

If yes, how much and in what length of time: _____

MEDICAL HISTORY

Do you now have or have you ever had:

- High Blood Pressure ___ Yes ___ No Sinus Problems ___ Yes ___ No
Allergies ___ Yes ___ No Heart Problems ___ Yes ___ No
Asthma ___ Yes ___ No Stroke ___ Yes ___ No
Tonsillectomy ___ Yes ___ No Nasal Fracture ___ Yes ___ No
Nasal Surgery ___ Yes ___ No Diabetes ___ Yes ___ No
Chronic Obstructive Pulmonary Disease ___ Yes ___ No
Nocturnal Esophageal Reflux ___ Yes ___ No
Swelling of Hands or Feet ___ Yes ___ No
Laser Surgery for Snoring ___ Yes ___ No
Head Injury or Concussion ___ Yes ___ No If yes, when? _____
A Previous Sleep Study ___ Yes ___ No If yes, when? _____

Other Medical Problems: _____

Table with 3 columns: List Medications & Strengths, Frequency, Reason for Medication

Table with 2 columns: List all Surgeries, Year

Allergies to Medications: _____

SLEEP HISTORY

Describe in detail what your sleep problem is and how long this has been a problem: _____

Are you currently being treated for the above mentioned problem?: Yes No

If yes, How?: _____

Normal Bedtime: Weeknights _____ Weekends _____

Normal Wake up time: Weekdays _____ Weekends _____

When you awaken in the morning do you feel refreshed? Yes No

How long does it usually take you to fall asleep once the lights are turned off?: _____

Do you awaken during the night?: Yes No

How many times do you awaken during the night?: _____

How long does it take for you to return to sleep upon these awakenings?: _____

Do you take naps during the day?: Yes No

If yes, how often?: _____ Average length: _____

Do you feel refreshed upon awakening from these naps?: Yes No

Note the positions you normally sleep in: Back Right side Left side Stomach

Are you now or have you ever been in the care of a Cardiologist?: Yes No

Please mark the appropriate space:

1. Do you snore? Yes No Sometimes
2. Do you snore while lying on your back? Yes No Sometimes
3. Do you snore while lying on your side? Yes No Sometimes
4. Rate your snoring Mild Moderate Loud
5. Do you hold your breath or stop breathing in your sleep? Yes No Sometimes
6. Do you have difficulty breathing while lying on your back? Yes No Sometimes
7. Do you have difficulty breathing while lying on your side? Yes No Sometimes
8. Do you awaken suddenly with a choking sensation or out of breath? Yes No Sometimes
9. Do you have gas, indigestion or heartburn at night? Yes No Sometimes
10. Do you have night sweats? Yes No Sometimes
11. Do you awaken with headaches in the morning? Yes No Sometimes
12. Do you awaken with a dry mouth? Yes No Sometimes
13. Do you have trouble breathing through your nose? Yes No Sometimes
14. Do you experience shortness of breath with exertion? Yes No Sometimes
15. How many times do you awaken at night to urinate? _____ times
16. When you awaken from sleep, do you feel paralyzed, unable to move even though you are awake? Yes No Sometimes
17. When someone startles you or makes you laugh, do you get weak, fall or do your knees buckle? Yes No Sometimes

- 18. While in the process of falling asleep, do you have vivid dreams or hallucinations? Yes No Sometimes
- 19. Do you have frequent uncontrollable bouts of sleep, sleep attacks or an irresistible urge to sleep? Yes No Sometimes
- 20. Do your legs kick or twitch frequently during the night? Yes No Sometimes
- 21. Do you have restless legs? Yes No Sometimes
- 22. Do you have problems with memory or concentration? Yes No Sometimes
- 23. Problems with impotence or lack of sexual drive? Yes No Sometimes
- 24. Are you irritable? Yes No Sometimes
- 25. Do you feel depressed? Yes No Sometimes
- 26. Do you feel anxious? Yes No Sometimes
- 27. Do you grind your teeth at night? Yes No Sometimes
- 28. Do you feel sleepy during the day? Yes No Sometimes
- 29. Do you feel fatigued during the day? Yes No Sometimes
- 30. Do you have to fight sleep while driving? Yes No Sometimes
- 31. Have you ever had a car wreck caused by sleepiness? Yes No Sometimes

Please rate the chance of you dozing in the following situations:

- 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 (e.g. 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 a lunch without alcohol
- In a car, while stopped for a few minutes in traffic
- Add the numbers for a total:

Chance of dozing:

(Total) _____

SLEEP ENVIRONMENT

- Do you sleep in a waterbed? Yes No
- Do you read in bed? Yes No
- Do you watch T.V. in bed? Yes No
- Do you share the bed with anyone? Yes No
- Does your bed partner have a sleep disorder? Yes No
- Do you have pets in the bedroom? Yes No
- What is the temperature in your bedroom? _____

SOCIAL HISTORY

Marital Status: Single Married Domestic Partner Widowed

What is your present occupation? _____

What are your work hours? _____

Have you ever smoked? Yes No

If yes, for how many years? _____

Average number of packs per day _____

Have you quit smoking? Yes No

How long ago? _____

Do you drink caffeinated beverages? Yes No

If yes, how much per day? _____

Do you drink alcoholic beverages? Yes No

If yes, how often? _____

Do you get regular exercise? Yes No

If yes how often? _____

Do you have any unusual eating habits? Yes No

If yes, explain _____

FAMILY HISTORY

Children: Number _____ Ages _____ Health _____

Mother: Living: Yes No Age: _____ Health _____

Father: Living: Yes No Age: _____ Health _____

Brothers: Number _____ Ages _____ Health _____

Sisters: Number _____ Ages _____ Health _____

Do any members of your family have sleep problems? If so, please describe: _____

Now that you have answered our questionnaire, do you have any other comments that you would like to add?

Thank you for taking the time to prepare for your first appointment!