



PATIENT SLEEP HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ 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
A Previous Sleep Study \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

Table with 3 columns: List Medications & Strengths, Frequency, Reason for Medication. Includes multiple rows for data entry.

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.