Sleep Medicine Consultants

PATIENT SLEEP HISTORY QUESTIONNAIRE **Date:** _____

Name:_____ **Gender:** ☐ **M** / ☐ **F**
Date of Birth:_____ **Age:** _____ **Height:** _____ **Weight:** _____
Race: _____ **Ethnicity:** _____ **Preferred language:**_____
Referring Physician/Provider:_____
Does any other medical provider need to receive a copy of your report? ☐ **No**
☐ **Yes (up to 2)** _____, _____

Have you had a recent <u>significant</u> weight gain or 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 _____ & where? _____

Other Medical Problems:_____

_____

_____

List Medications & Strengths:	**Frequency:**	**Reason for Medication:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. Rate your snoring ____Mild ____Moderate ____Loud
3. Do you hold your breath or stop breathing in your sleep? ____Yes ____No ____Sometimes
4. Do you have difficulty breathing while lying on your back? ____Yes ____No ____Sometimes
5. Do you have difficulty breathing while lying on your side? ____Yes ____No ____Sometimes
6. Do you awaken suddenly with a choking sensation or out of breath? ____Yes ____No ____Sometimes
7. Do you have gas, indigestion or heartburn at night? ____Yes ____No ____Sometimes
8. Do you have night sweats? ____Yes ____No ____Sometimes
9. Do you awaken with headaches in the morning? ____Yes ____No ____Sometimes
10. Do you have trouble breathing through your nose? ____Yes ____No ____Sometimes
11. How many times do you awaken at night to urinate? _____ times
12. Have you ever awakened from sleep and felt paralyzed, unable to move even though you are awake? ____Yes ____No ____Sometimes
13. When someone startles you or makes you laugh, do you feel weakness in any muscles (including your face) or fall down? ____Yes ____No ____Sometimes
14. While in the process of falling asleep, do you have vivid dreams or hallucinations? ____Yes ____No ____Sometimes
15. Do you have frequent uncontrollable bouts of sleep, sleep attacks or an irresistible urge to sleep? ____Yes ____No ____Sometimes
16. Do your legs kick or twitch frequently during the night? ____Yes ____No ____Sometimes

17. Do you have restless legs? ____Yes ____No ____Sometimes
18. Do you have problems with memory or concentration? ____Yes ____No ____Sometimes
19. Do you feel depressed or anxious? ____Yes ____No ____Sometimes
20. Do you grind your teeth at night? ____Yes ____No ____Sometimes
21. Do you feel sleepy during the day? ____Yes ____No ____Sometimes
22. Do you feel fatigued during the day? ____Yes ____No ____Sometimes
23. Do you have to fight sleep while driving? ____Yes ____No ____Sometimes
24. Have you ever had a car wreck caused by sleepiness? ____Yes ____No ____Sometimes

SLEEP ENVIRONMENT

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:	**Chance of dozing:**
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:	(Total)_____

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? _____

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!