SLEEP HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Sex: _____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to provide a description of your background and the nature of your present sleep problem. Please complete these as thoroughly as possible. All information obtained is confidential and privileged.

Describe your main sleep problem(s) in your own words and describe what treatment you have received for this in the past.

_____

_____

_____

1. How often does this problem occur?

   ( ) almost every night

   ( ) for periods of at least one week

   ( ) irregularly

   ( ) other

_____

2. How long has this problem bothered you?

   ( ) more than 2 years

   ( ) more than 1 year

   ( ) several months

   ( ) within the last month

3. How would you rate the severity of your sleep problem?

   ( ) Mild

   ( ) Moderate

   ( ) Severe

   ( ) Very severe

4. Do any other members of your family have sleep problems? Please Explain.

_____
_____
_____

5. How many hours of sleep do you usually get per night?_____

6. What time do you go to bed on weekdays? _____Weekends?_____

7. What time do you wake up on weekdays? _____Weekends?_____

8. How long does it take for you to fall asleep? _____

9. How many times do you typically wake up at night? _____

10. If you wake up, on average, how long do you stay awake?
_____

11. What do usually do when you awake during the night? _____

12. On the average, how long do you stay in bed after waking up in the morning?

13. Do you sleep with someone else in your bed? _____someone else in the same room?_____

14. Do you work split shifts or rotating shifts? _____

15. Do you usually have drinks containing caffeine within 2 hours before bedtime? _____

16. Do you physically exercise before you go to bed?
_____

17. Do you read or watch TV while in bed before going to sleep? _____

18. Do you take naps during the afternoon or evening? _____

19. Do you feel refreshed after a short (10-15 minute) nap ? _____

20. How do you feel after an average night of sleep? _____

    ( ) drowsy

    ( ) tired for a few hours

    ( ) tired all day

    ( ) rested

    ( ) energetic

21. Is you present work situation satisfactory? ____Does your sleep problem affect your work? ____

22. If your present social life satisfactory? ___Does your sleep problem affect your social activity___

23. Please rate how often you:

Use code: **N**: Never or No R: Rarely **O**: Occasionally **F**: Frequently **C**: Constantly

Have difficulty falling asleep	**N**	**R**	**O**	**F**	**C**
Wake up during the night	**N**	**R**	**O**	**F**	**C**
Have excessive daytime sleepiness	**N**	**R**	**O**	**F**	**C**
Have difficulty waking from sleep	**N**	**R**	**O**	**F**	**C**
Awaken from sleep short of breath	**N**	**R**	**O**	**F**	**C**
Awaken at night with heartburn, belching or cough	**N**	**R**	**O**	**F**	**C**
Snore	**N**	**R**	**O**	**F**	**C**
Suddenly wake up gasping for breath	**N**	**R**	**O**	**F**	**C**
Have breathing problems during sleep (observed by self or others)	**N**	**R**	**O**	**F**	**C**
Sweat heavily during sleep	**N**	**R**	**O**	**F**	**C**
Notice your heart pounding during sleep	**N**	**R**	**O**	**F**	**C**
Fall asleep during the day	**N**	**R**	**O**	**F**	**C**
Fall asleep while driving	**N**	**R**	**O**	**F**	**C**
Experience loss of muscle tone when extremely emotional	**N**	**R**	**O**	**F**	**C**
Feel unable to move (paralyzed) when waking or falling asleep	**N**	**R**	**O**	**F**	**C**
Have vivid dream when waking or falling asleep	**N**	**R**	**O**	**F**	**C**
Feel afraid to go to sleep	**N**	**R**	**O**	**F**	**C**
Have trouble at work or school because of sleepiness	**N**	**R**	**O**	**F**	**C**
Have nightmares	**N**	**R**	**O**	**F**	**C**
Walk in your sleep	**N**	**R**	**O**	**F**	**C**
Remember your dreams	**N**	**R**	**O**	**F**	**C**

Talk in your sleep **N R O F C**

Wet the bed **N R O F C**

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Have anxiety **N R O F C**

Notice parts of your body jerk **N R O F C**

Kick your legs during sleep **N R O F C**

Experience crawling and aching felling in your legs during sleep **N R O F C**

Experience leg pain during sleep **N R O F C**

Experience any other pain during sleep **N R O F C**

24. List your consumption of the following per day:

Cigarettes ( ) Yes Packs per day _____

( ) No

( )Used to smoke Packs per day _____

Caffeine ( ) Yes Beverages per day _____

( ) No

Alcohol ( ) Yes Beverages per day _____

( ) No

Recreational drugs ( ) Yes Drugs used_____how often:_____

( )No

Medical History

Year of last full physical exam:_____ Year of previous sleep study:_____

Number of auto accidents in last 12 months:_____ Have you ever had a head or neck injury _____

Weight gain in the last 12 months:_____ Weight loss in the last 12 months:_____

Current / Preferred home health care company

_____

Do you have any of the following:

High blood pressure ____ Heart disease ____ Diabetes____ Acid reflux____

Depression ____ Seasonal allergies____ Stroke/CVA____

Medications

Please list all Prescription medications that you are taking now

MEDICATION FREQUENCY DOSAGE

Please list all NON-PRESCRIPTION medications that you are taking now

MEDICATION FREQUENCY DOSAGE