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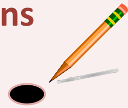
Sleep History

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

Gender ◯ Male ◯ Female
Race ◯ African-American ◯ Hispanic ◯ Asian or Pacific Islander ◯ Caucasian / White ◯ American Indian / Native American
Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
Number of Marriages ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5+
Number of Children ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8+

What is your height?
Feet ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7
Inches ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11

What is your current weight?
◯ 100 ◯ 200 ◯ 300 ◯ 400 ◯ 500 ◯ 600
Pounds ◯ 10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ 60 ◯ 70 ◯ 80 ◯ 90
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9

What is your previous weight? (one year ago)
◯ 100 ◯ 200 ◯ 300 ◯ 400 ◯ 500 ◯ 600
Pounds ◯ 10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ 60 ◯ 70 ◯ 80 ◯ 90
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9

What is the **highest grade** you finished in school?
◯ Grades 1-8
◯ Grades 9-11
◯ High school graduate / GED equivalent
◯ Junior college / vocational degree
◯ Some college (less than 4 years)
◯ College degree
◯ Advanced degree (Masters, PhD, MD, JD)

Do you have **military experience**? ◯ Yes ◯ No
Combat experience? ◯ Yes ◯ No

SAMPLE

Employment History

How would you describe your Employment? *(Please choose only one response)*
◯ Homemaker ◯ On disability ◯ Unemployed ◯ Retired ◯ Full time ◯ Part time

Occupation: ______________________________

Do you have any of the following job requirements?
◯ Work rotating shifts
◯ Driving a vehicle
◯ Work with hazardous substances
◯ Work night shift
◯ Work with dangerous equipment or in hazardous situations
◯ None of the above
◯ Travel across time zones

What is your sleep problem?
◯ Stop breathing while asleep
◯ Snoring
◯ Sleeping more now than a year ago
◯ Difficulty falling asleep
◯ Excessive daytime sleepiness
◯ Unusual behaviors during sleep or during awakenings from sleep
◯ **Other:** ______________________________
◯ Difficulty staying asleep
◯ Excessive fatigue

Is your sleep problem ◯ Getting better ◯ Getting worse ◯ Staying the same

Who INITIALLY suspected a sleep problem? ◯ You ◯ Your spouse / bed-partner / roommate ◯ Your physician

If your physician suspects a sleep disorder, what is his/her practice **specialty** (Choose one)
◯ Family Practice / Internal Medicine
◯ Pulmonary Medicine (Lung Specialist)
◯ Ear, Nose and Throat Specialist
◯ Neurologist
◯ Cardiologist
◯ Other

Do you currently have a bed partner/roommate? ◯ Yes ◯ No
If yes, did your bed partner / roommate assist with this questionnaire? ◯ Yes ◯ No

Have you ever had a sleep study before? ◯ Yes ◯ No
If yes, were you diagnosed with a sleep disorder? ◯ Yes ◯ No
What disorder: ◯ Sleep apnea ◯ Insomnia ◯ Narcolepsy ◯ Restless sleep
◯ **Other:** ______________________________
What treatments have you had: ◯ CPAP/BiPAP ◯ Medication ◯ Oxygen ◯ Dental device
◯ **Other:** ______________________________

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Because of your sleep problems, have you:

Considered (or are on) disability? ◯ Yes ◯ No
Had work (or school) difficulties? ◯ Yes ◯ No
Had motor vehicle accidents? ◯ Yes ◯ No
Had driving problems? ◯ Yes ◯ No
Marital or social problems? ◯ Yes ◯ No
Drug or alcohol use? ◯ Yes ◯ No
Had an injury? ◯ Yes ◯ No

The following questions are related to your sleep during the past few months.

WEEKDAYS

When do you usually go to sleep?

AM											NOON												PM
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

When do you usually wake up?

AM											NOON												PM
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

Do you use an alarm to awaken? ◯ Yes ◯ No

WEEKENDS

When do you usually go to sleep?

AM											NOON												PM
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

When do you usually wake up?

AM											NOON												PM
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

Do you use an alarm to awaken? ◯ Yes ◯ No

SAMPLE

	<3	4 to 6	7	8	9	10 to 12	>12
How many hours do you try to sleep?	◯	◯	◯	◯	◯	◯	◯
How long do you actually sleep?	◯	◯	◯	◯	◯	◯	◯

How satisfied are you with your... *Very Satisfied..................................to.................................Very Dissatisfied*

Current sleep quality?	1	2	3	4	5	6	7
Current daytime alertness?	1	2	3	4	5	6	7
Ability to feel rested after your night's sleep?	1	2	3	4	5	6	7

How long do you lay in bed before falling asleep?
◯ < 15 min ◯ 15 - 30 min ◯ 31 - 45 min ◯ 46 - 60 min ◯ > 1 hr

How many times do you typically awaken during the night? ◯ Once or less ◯ 2 to 3 ◯ 4 to 5 ◯ 6+

How many times do you typically awaken to use restroom? ◯ Once or less ◯ 2 to 3 ◯ 4 to 5 ◯ 6+

If you awaken during the night, what is the total time you are unable to sleep between bedtime and your final wake-up time:
◯ < 15 min ◯ 15 - 30 min ◯ 31 - 45 min ◯ 46 - 60 min ◯ > 1 hr

When unable to sleep, do you do any of the following:
◯ Watch TV or listen to music or radio in bed ◯ Eat ◯ Read
◯ Use computer or internet ◯ Worry at night ◯ **Other:** ____________________

Describe any problems in your sleeping environment: ◯ Uncomfortable temperature
◯ Noisy room ◯ Excessive light ◯ Bed partner interrupts sleep
◯ Uncomfortable bed ◯ Pet interference ◯ **Other:** ____________________

Do you take naps or doze off during the day? ◯ Yes ◯ No

If yes, **how many days per week do you take naps or doze off unintentionally**?
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7

If yes, h**ow long do you sleep during the day**?
◯ < 15 min ◯ 15 to 30 min ◯ 31 to 45 min ◯ 46 to 60 min ◯ > 1 hr

How do you **feel after a nap**? ◯ Rested ◯ Tired

Do you **often dream during a nap**? ◯ Yes ◯ No

Do your legs have a "creepy, crawling" sensation while sitting or lying quietly that causes an almost irresistible urge to move your legs? ◯ Yes ◯ No

If yes, what time of day? ◯ Morning ◯ Afternoon ◯ Evening ◯ All day
If yes, rate the severity of this feeling: ◯ Mild ◯ Moderate ◯ Severe
If yes, does this feeling in your legs interfere with your sleep? ◯ Yes ◯ No
If yes, does movement of your legs give you temporary relief? ◯ Yes ◯ No

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Never: Not experienced the problem in the last year
Rarely: Experience the problem less than once per month
Sometimes: Experience the problem a few times per month
Often: Experience the problem during most weeks of the month
Usually: Experience the problem 2 to 5 times per week
Always: Experience the problem on most days of the week

How often do you (or your bed partner/roommate) find that you:	Never	Rarely	Sometimes	Often	Usually	Always
Snore so loudly that it would bother others near you						
Sleep apart from your bed partner or roommate because of snoring						
Make unusual sounds while sleeping						
Have trouble breathing at night						
Awaken choking, gasping or smothering						
Awaken coughing						
Have others say that you stop breathing in your sleep						
Are bothered by physical problems, sensations or pain at night						
Awaken with dry mouth and/or sore throat						
Have palpitations or chest pain at night						
Awaken during the night or in the morning with a headache						
Are awakened with hot flashes or sweating						
Have twitches, jerks or startled movements during sleep						
Have restless sleep or awaken with bedclothes or sheets in a mess						
Sit up and scream while asleep or suddenly wake up scared						
Talk while sleeping						
Walk or eat while asleep, with no recall of this the next day						
Act out your dreams						
Afraid to be alone at night						
Grind teeth while sleeping						
Wet the bed						
Are tired and fatigued even when you are not sleepy						
Doze or nod off while at work						
Doze or nod off while driving						
Feel sleepy and drowsy all day						
Wake up tired or NOT rested						
Feel tired or sleepy in the morning						
Feel tired or sleepy during the afternoon						
Feel tired or sleepy in the early evening						
Are more awake and alert in the evening than morning						
Wake up and are alert in the morning before it is time to get up						
Sleep longer on weekends or holidays than on weekdays						
Have trouble falling asleep at your usual bedtime						
Have trouble staying asleep after you have fallen asleep						
Awaken early in the morning and have trouble getting back to sleep						
Lie awake at night with thoughts racing through your mind						
Are too full of energy or have many exciting/important things to do to sleep						
Have frightening dreams or nightmares						
Have vivid dreams shortly after falling asleep						
Heard a voice or saw things like a vision while falling asleep or awakening						
Felt paralyzed, totally unable to move, but mentally alert while falling asleep or wakening						
Have sudden physical weakness of arms, legs or face when laughing, crying, or during other emotional situations without dizziness						
Are refreshed and awake even after short (10-15 min) naps						
Use alcohol to help you sleep						
Use sleeping pills to help you sleep						
Use medicine to help you stay awake						
Use coffee, tea, cola or other stimulants to help you stay awake						

SAMPLE

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