Sleep History Questionnaire

Name: ________________________________ **DOB:** _______________ **Phone:** __________________

Date of Consultation: ____________ **Consultation is requested by:** _____________________________

Primary care provider: ___________________ **Preferred pharmacy:** ________________________

Chief complaint: ____

Please tell us why you are here: ____

____

____

____

____

How long has this been happening? ____

Have you been seen by a sleep specialist before? If so when, where and by whom?

____

SLEEP-WAKE SCHEDULE:

What is your *preferred* bedtime and wake time? ____

On weekdays what time do you go to sleep? ____

On weekdays what time do you awaken? ____

Do you use an alarm? ____

How quickly do you fall asleep? ____

Do you have difficulty falling asleep? ____

How many times do you awaken during the night? _____ What awakens you? _____________________

How long does it take before falling back to sleep? ____

On weekends what time do you go to sleep? ____

On weekends what time do you awaken? ____

How quickly do you fall asleep on weekends? ____

Do you have difficulty falling asleep on weekends? ____

Do you have a shift work job? ____

Do you take naps? ______How long and how often? ____

Are the naps refreshing or unrefreshing? ____

SLEEP COMPLAINTS: Please circle any that apply

Snoring	Shortness of breath	Stopping breathing	Morning headaches
Confusion	Leg jerking	Sleep walking	Rocking
Night eating	Dream enactment	Injury	Safety concerns
Sudden urges of sleep attacks		Drop attacks	Wake and can't move
Restlessness	Night terrors	Aspiration	Sweats
Nightmares	Teeth grinding	Bed wetting	Anxiety
Pain	Discomfort	Reflux	Heart pounding
Frequent urination		Ruminating thoughts	

Hallucinations upon entering sleep or waking from sleep

Other____

When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement? _______________________

PAST MEDICAL HISTORY: ____

____

____

____

____

Medication Allergies: ____

Current medications and doses: ____

____

____

____

Do you use oxygen at night? Yes or No. If so, what liter flow? ____________________

PAST SURGICAL HISTORY: ____

____

____

____

PSYCHIATRIC HISTORY: ____

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SOCIAL HISTORY: Which (if any) and how much of the following do you use currently?
Tobacco (now and previously): ____
Caffeine consumption (coffee, tea, soda, etc.): _______________________________
Last caffeine intake is usually before: ______________________________________
Supplements for wakefulness: ____
Alcohol: ____
Recreational Drugs: ____
What is your occupation and work hours? ____________________________________
Have you had any accidents or near accidents due to drowsy driving? ___________ What were the consequences? ____
Have you ever driven or traveled somewhere and not remember how you got there? ___________

FAMILY HISTORY: Please indicate if your biological parents had any of the following:

	Mother	Father
Restless legs		
Insomnia		
Nightmares		
Night terrors		
Sleep apnea		
Heart attack		

	Mother	Father
Congestive heart failure		
Stroke		
Diabetes		
High blood pressure		
Other		

Epworth Sleepiness Scale

Use the following scale to choose one number that best describes what has been happening to you during each activity over the last month. Write that number in the line below.

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Activities	Chances of falling asleep (0-3)
Sitting and reading	______
Watching TV	______
Sitting, inactive in a public place (e.g. a theater or a 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 the traffic	______
Total	______

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REVIEW OF SYSTEMS:

Have you gained weight over the last year? _____ If so how much? ______________________

Please circle those that apply. Any not circled will be reported as negative in your medical record.

Constitutional	Weight loss	Fever	Chills	Night sweats
Eyes	Vision changes	Double vision		
Head	Ear pain	Sore throat	Sinus pain	Post-nasal drip
	Runny nose	Bloody nose		
Cardiac	Fast heartbeats	Fluttering in chest	Chest pain or pressure	Short of breath when laying flat
	Swollen legs or feet			
Neurologic	Headaches	Seizure	Numbness in arms or legs	
Dermatologic	Rash			
Pulmonary	Shortness of breath at rest	Shortness of breath with activity	Productive cough	Coughing of blood
	Wheezing	Dry cough		
Gastrointestinal	Nausea	Vomiting	Loose or watery stools	Constipation
	Abdominal pain	Black stools	Blood in stool	
Musculoskeletal	Muscle pain	Bone pain	Joint pain	Swollen joints
Endocrine	Increased thirst	Frequent urination	Diabetes	
Lymphatic	Swollen lymph nodes			

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PATIENT AGREEMENT

Sleep and Driving Do Not Mix

If you are currently experiencing excessive daytime sleepiness or fatigue you should NOT drive until you are sure your sleepiness is under control. Driving while experiencing fatigue may put you at an increased risk for falling asleep while driving. If you have concerns about your level of daytime sleepiness, you should consult physician.

After you start driving again, please remember the following:

1. Do not drive alone for long periods of time.
2. Drive only when most alert and stop frequently to refresh yourself.
3. Do not push yourself beyond your limites. Do no drive if you feel you cannot keep your eyes open.

I have been instructed and understand the warning about fatigue and driving. I understand that because of daytime sleepiness I may be at an increased risk for falling asleep while driving.

__________________________________ ________________ __________________

Patient Signature Date of Birth Date

__________________________________ ________________

Witness Signature Date

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