

THANK YOU FOR TAKING A FEW MINUTES TO ANSWER the following questions about your sleep history. Please return this form in the enclosed self-addressed envelope, hand carry, fax, or email.

THIS INFORMATION NEEDS TO BE REVIEWED BY THE SLEEP PHYSICIAN PRIOR TO YOUR SCHEDULED APPOINTMENT AND BEFORE YOU CAN BE APPROVED FOR THE "MOVE-UP" LIST.

*This information will help in the diagnosis of your sleep disorder and will assist our physician(s) in formulating treatment recommendations. What a bed partner or other family member may have noticed while you were sleeping is also very helpful.*

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF APPOINTMENT: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_ Email address

HOME PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_ CELL# \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_ REFERRING MD: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_  Active  Sedentary (primarily sitting down)

BEST TIMES TO REACH ME AT WHICH PHONE

1. What is your concern/complaint about your sleep?

\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever had a sleep study before?  Yes  No

If yes, please state when \_\_\_\_\_, where \_\_\_\_\_. What you were told the sleeping problem was?

\_\_\_\_\_  
What was recommended for treatment?

What recommendations have you tried?

Have they helped?  Yes  No

3. Do you snore?  Yes  No

If yes, how old were you when you started snoring?

Do you snore in  certain positions  all positions?

Only these positions:

Is your snoring getting  louder  more frequent?

4. Do you stop breathing (apnea) while sleeping?  Yes  No

If yes, how long do the apneas last?

When did someone first notice the apnea?  
\_\_\_\_\_

5. Is snoring/apnea worse with severe fatigue or intake of alcohol?  Yes  No

6. Has snoring/apnea become worse with weight gain?  Yes  No

What is the most you have ever weighed? \_\_\_\_\_ When?

What is your best weight? \_\_\_\_\_ When did you last weigh that?

What is your current weight? \_\_\_\_\_ What is your height?

7. Do you wake up at night gasping for breath?  Yes  No

If yes, how many nights \_\_\_\_\_ week? \_\_\_\_\_ month?

8. Do you wake up at night with heart pounding or chest pain?  Yes  No
9. Do you wake up at night with indigestion/heartburn or acid in the throat?  
Do you often use antacids, Tums, etc.?  Yes  No
10. Is the head of your bed elevated at home?  Yes  No  
If yes, how many inches?  
How many pillows do you use? \_\_\_\_\_ Do you sleep in a waterbed?  Yes  No
11. Do you have night sweats--pajamas, gown or pillow damp?  Yes  No
12. Is your mouth dry in the morning?  Yes  No
13. Do you wake up with headaches?  
If yes, how often and how long do they last?  Yes  No
14. Do you take any medications for the headaches?  
If yes, what medications do you take and how often?  Yes  No
15. Did you ever have your tonsils or adenoids removed?  
If yes, at what age? \_\_\_\_\_  Yes  No
16. Have you had any injuries or surgery to your nose, face, neck or jaw?  
If yes, at what age(s)? \_\_\_\_\_  Yes  No  
For what reason(s)? \_\_\_\_\_  
Name & location of facility:  
Physician:
17. Do you wear a bite guard or dental appliance while sleeping?  Yes  No  
Why?  Teeth grinding,  Snoring,  Other \_\_\_\_\_.
18. Do you wear dentures?  Yes  No  
If yes, are they?  Full,  Partial,  Top only,  Bottom only.  
Do you sleep with them in?  Never,  Sometimes,  Always.
19. Do you have a history of sinus problems (allergies, infections, congestion)?  Yes  No
20. Have you used nasal steroid sprays (ex, Flonase, Nasocort)?  Yes  No
21. Do you use "over the counter" decongestant sprays (Afrin etc.)  Yes  No
22. Have you tried or do you use Breath-right strips?  Yes  No
23. Do you wake up at night to go to the bathroom?  
If yes, approximately how many times?  Yes  No
24. Are you a restless sleeper--toss and turn and tear up the covers at night?  Yes  No
25. Do bed partners or others observe arm movement or leg kicks at night?  Yes  No
26. Do you have "restless legs" at bedtime--a feeling in the legs as if you need to get up and walk around or stretch or rub your legs?  Yes  No  
If yes, do these feelings occur if you must sit still for awhile, such as car or airplane trips?  Yes  No
27. Does anyone else in your family have the same "restless legs" feeling  Yes  No

28. In the past, how many hours of sleep have you felt best for you? \_\_\_\_\_.
29. How many hours per night do you sleep now? \_\_\_\_\_.
30. After a usual night's sleep, how do you feel in the morning?  Still sleepy,  Very hard to wake up.  
 Rested,  Other
31. What time do you usually go to bed?  
What time do you usually get up?
32. Are these hours different on weekends, holidays, etc.?  Yes  No  
If yes, how are they different?
33. Do you ever take naps?  Yes  No  
If yes, for how long and do you feel refreshed afterwards?
34. Are you a shift worker?  Yes  No  
If yes, indicate how often you change shifts and which shifts you work.
- If you are a shift worker, it would be most helpful if you would document a sample two-week working/sleeping schedule by completing a Sleep Log.
35. Do you have problems with daytime sleepiness?  Yes  No
36. Use the following scale to choose the most appropriate number for each situation:  
0 = would never, 1 = slight chance, 2 = moderate chance of dozing, 3 = high chance of dozing.

Situation	Chance of dozing (0 to 3)
Sitting and reading.	
Watching Television.	
Sitting inactive in a public place; for example, a theater or meeting.	
As a passenger in a car for an hour without a break.	
Lying down to rest in the afternoon.	
Sitting and talking to someone.	
Sitting quietly after lunch (without alcohol).	
In a car, while stopped in traffic.	
<b>Total score</b>	

37. Have you had any minor or major traffic accidents caused by sleepiness?  Yes  No
38. Has your memory gotten worse lately?  Yes  No
39. Has your ability to concentrate and/or perform repetitive tasks (like balancing a checkbook, etc.) decreased?  Yes  No

40. Have family members or co-workers mentioned that you seem irritable or short tempered recently?  Yes  No
41. When falling asleep or just before awakening, have you been aware of your surroundings and wanted to respond but felt paralyzed?  Yes  No
42. Are your dreams so vivid that sometimes you confuse them with reality?  Yes  No
43. Do you have dream like experiences as if you are partially asleep or partially awake?  Yes  No  
If yes does it happen:  when falling asleep  when waking up?
44. Are you confused upon awakening or do you do things automatically (like shower, dress or drive to work) without remembering, especially in the morning?  Yes  No  
If yes, do you do this at other times of the day also?  Yes  No
45. Please mark the areas in which you may suddenly feel weak, the appropriate circumstance and frequency.

	When angry	When sad	When laughing	When surprised	With physical activity	At meals	Rarely Daily Or Weekly
Knees							
Neck							
Jaw							
Arms							

46. Have you awakened with an injury to yourself that was not there when you went to bed, or have bed partners said you injured them in your sleep, but you have no recollection of such behaviors?  Yes  No
47. Have you discovered or been told you were up  walking, or  eating during the night, but have no recollection of having done so.  Yes  No
48. Do you often have trouble falling asleep?  
If yes, how many nights a week? \_\_\_\_\_ a month  Yes  No
49. How long does it take you to fall asleep?
50. Once asleep, do you have trouble staying asleep?  Yes  No
51. Approximately how many times a night do you remember waking up?
52. Do you have trouble going back to sleep if you wake up?  Yes  No
53. What remedies have you tried to help you sleep?

REMEDY	YES	
Sleeping pills		How often? _____ What kind?
Tryptophan		How much?
Melatonin		How much?

Snack at bedtime		_____ Milk?
Exercise		What kind? _____ What time of day? _____ How many times a day? _____ How many days per week? _____
Relaxation therapy, biofeedback, etc.		

54. Do you:  read in bed,  watch TV in bed,  do paper (business) work in bed?  Yes  No
55. When unable to sleep, do you:  never happens,  lie in bed,  watch the clock,  get up and do something? If so, what?
56. Is it easier to fall asleep in another room or on the sofa/in an easy chair?  Yes  No
57. On holidays or vacations (especially away from home) is your sleep better?  Yes  No  
If yes, why do you think that is? \_\_\_\_\_
58. If you could set your own hours for bedtime and getting up, what would they be?  
Bedtime: \_\_\_\_\_ Wake time: \_\_\_\_\_
59. Do you smoke or use smokeless tobacco?  Yes  No  
If yes, how long and how much do you smoke or chew?  
If you quit, how many years did you smoke or chew?  
How many packs or how much chew a day?  
When and why did you quit?
60. Do you drink caffeinated beverages?  Yes  No  
If yes, how many caffeinated cups of coffee/tea do you drink per day? \_\_\_\_\_. How many caffeinated colas per day? \_\_\_\_\_. When do you drink the last one of the day?
61. Do you suffer from chronic pain that disturbs your sleep?  No,  Rarely,  Frequently,  Nightly.  
If so, where is it located? \_\_\_\_\_. Typically, how bad is it on a scale of 1 to 10. Ten being the most severe? (circle) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.
62. Is your pain so intense it keeps you from falling asleep, or awakens you?  Yes  No
63. If so, how often (# of times per night, nights per week, month etc.)
64. Is there something that you do that helps ease the pain so you can fall asleep?  Yes  No  
What is it? \_\_\_\_\_
65. Do you drink alcohol?  Yes  No  
If yes, how many times and drinks per week or month do you have? \_\_\_\_\_
66. Did you used to drink more heavily?  Yes  No  
If yes, how much and how many years ago?
67. Do you or have you used "street drugs" (uppers, downers, narcotics, hallucinogens, cocaine) in the past year?  Yes  No
68. Do you take any medications regularly?  Yes  No  
If yes, please list names and dosages:

69. Are you allergic to any medications?  Yes  No  
If yes, please list those medications:

**YOUR MEDICAL HISTORY:**

70. List any hospitalizations for medical or surgical problems stating the dates and reasons:  
\_\_\_\_\_  
\_\_\_\_\_

71. Do you have a history of high blood pressure?  Yes  No  
If yes, when were you first told of it?  
Were you/are you on treatment for high blood pressure:  Yes  No  
What is/was that treatment (name any medications used)?

72. Do you have heart trouble?  Yes  No  
If yes, when were you first told of it?  
Were you/are you on treatment for heart trouble?  Yes  No  
What is/was that treatment (name any medications used)?

73. Do you have lung disease such as asthma, emphysema, etc ?  Yes  No  
If yes, when were you first told of it?  
Were you or are you on treatment for a lung disease?  Yes  No  
Do you use supplemental oxygen:  No,  all the time,  only at night,  during exercise?  
If you come to the Center will you need to have enough oxygen in the tank for the trip here and home.  
Do you take Respiratory Treatments? If so, how often \_\_\_\_\_  Yes  No  
What is or was the treatment (name any medications or therapy used)?

74. Do you have any thyroid problems (over or underactive)?  Yes  No  
If yes, when were you first told of it?  
Were you/are you on treatment for thyroid problems?  Yes  No  
What is or was that treatment (name any medications used)?

75. Do you have diabetes?  Yes  No  
If yes, when were you first told of it?  
Were you/are you on treatment for diabetes?  Yes  No  
What is or was that treatment (name any medications used)?

76. Do you?  Use a wheel chair,  Need assistance at bed time or in the mornings for activities like dressing or going to the bathroom.  None of the above.

**QUESTIONS FOR WOMEN:**

77. Have you completed menopause or are you menopausal now?  Yes  No

78. Are you on female hormones?  Yes  
 No

If yes, please give the name and dosage and state how long you have been taking them.

79. Are you on other medications for menopause?  Yes  No  
 If yes, please give the name and dosage and state how long you have been taking them.

**FAMILY HISTORY:**

Please state the ages, states of health or if deceased the causes of death for the following:

Relative	Age	State of health or age at death and cause, if known.
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Check any of the following that may be present in your family history and list which members are affected:

CONDITION	YES	FAMILY MEMBER AFFECTED
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<b>Loud Snoring</b>		
<b>Narcolepsy</b>		
<b>Sleep apnea</b>		
<b>Sudden death in sleep</b>		
<b>High blood pressure</b>		
<b>Other</b>		

**If there is any additional information regarding your sleep that you feel may be significant, or are concerned about please use the space below. If not, thank you for taking the time to complete this questionnaire. It is an integral part of your complete sleep evaluation. Your Sleep physician cannot begin testing or make a diagnosis without it.**

questionnaire 2/02