

Sleep History

Patient Name:		DOB:		Age:
Gender:	Height:	Weight:	Neck Circumference:	
Telephone:		E-Mail Address:		

Referring Physician: <DB.Study.ReferralPhysician.FirstName> <DB.Study.ReferralPhysician.LastName>

Have you ever had a sleep study before? **Yes No** Where? _____

If you use CPAP or Oxygen, what pressure or level do you use? _____

Are you receiving **any** treatment for a sleep disorder(s)? **Yes No** If yes, describe below.

Briefly describe your sleep complaint/problem:

When is your usual bed time? _____ When is your usual wake time? _____

How long does it usually take you to fall asleep? _____ How many hours do you sleep per night _____

How often do you usually wake up at night? _____ What is your occupation? _____

- | | |
|--|---------------|
| Do you keep a regular <u>sleep</u> schedule? | Yes No |
| Do you have a regular <u>work</u> schedule? | Yes No |
| Are you a shift worker? | Yes No |
| Do you work a rotating shift? | Yes No |
| Do you work in a hazardous environment? | Yes No |
| Do you work in a quiet environment? | Yes No |

Describe your work **environment** and your work **schedule** below.

Do you use Tobacco products?	Yes No	How much per day?
Did you ever use Tobacco products?	Yes No	How much per day?
Do you eat/drink caffeine? (Chocolate, soda, coffee, tea, etc)	Yes No	How much per day?
Do you consume alcohol?	Yes No	How much per day?
Do you exercise?	Yes No	How often?

Are you on a diet?	Yes No
Has your weight fluctuated in the past?	Yes No
How much weight have you lost _____ or gained _____ in the last year?	
Do you usually consume alcohol or caffeine during the last 4 hours before your bedtime?	Yes No
Do you usually exercise during the last 4 hours before bedtime?	Yes No
Do you have a bed partner or witness who complains about your sleep habits?	Yes No
Have any of your family members had a sleep disorder?	Yes No
Do you have any tape or latex allergies?	Yes No

Daytime Symptoms

1. Do you usually feel sleepy or fatigued during the day?	Yes No
2. Do you usually take naps during the day?	Yes No
3. If the opportunity were available, would you take naps during the day?	Yes No
4. Could you take naps after arriving home from work?	Yes No
5. Have you had accidents or near accidents due to sleepiness or fatigue?	Yes No
6. Do you fall asleep before noon if not active?	Yes No
7. Do you fall asleep during active tasks before noon?	Yes No
8. Do you experience sleepiness after lunch or other meals?	Yes No
9. Do you fall asleep in the afternoon if you are not active?	Yes No
10. Do you fall asleep during active tasks in the afternoon?	Yes No
11. Have you ever fallen asleep while driving?	Yes No
12. Have you ever fallen asleep while at work or school?	Yes No
13. Has sleepiness or fatigue interfered with your work, home, or social activities?	Yes No
14. Do you feel rested when waking up in the morning?	Yes No
15. Do you find yourself performing routine activities and/or driving without thinking?	Yes No
16. Have you ever gone about performing a task only to find you have already done it?	Yes No
17. During strong emotions have you ever felt physical weakness or even fallen?	Yes No
18. Do you have pain or headaches during the day?	Yes No
19. Do you have difficulty concentrating or performing repetitive tasks during the day?	Yes No
20. Do you have the urge to move your legs or have "restless legs"?	Yes No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. **Choose the most appropriate number for each situation.**

0 = Would never fall asleep **1** = Slight chance of dozing **2** = Moderate chance of dozing **3** = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place (i.e., theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

Total _____

Falling Asleep

- | | | |
|---|-----|----|
| 1. Are you unable to fall asleep in 15 minutes or less? | Yes | No |
| 2. Do you awaken often while trying to fall asleep? | Yes | No |
| 3. Do you have thoughts racing through your mind while trying to fall asleep? | Yes | No |
| 4. Do you watch a clock while trying to sleep? | Yes | No |
| 5. Do you watch Television to help you fall asleep? | Yes | No |
| 6. Do you use "white noise" (fans, sound machines, etc) devices to help you fall asleep? | Yes | No |
| 7. Do you have anxiety, which keeps you from sleeping? | Yes | No |
| 8. Do environmental sounds keep you from getting to sleep quickly? | Yes | No |
| 9. Do you usually stay up late and feel you could sleep late in the morning? | Yes | No |
| 10. Do you usually go to bed early only to find yourself waking early in the morning? | Yes | No |
| 11. Do you experience crawling and achy feelings in your legs, which make you want to move? | Yes | No |
| 12. Do these achy feelings seem to be worse at bedtime? | Yes | No |
| 13. Do you have muscle tension, which disrupts your ability to fall asleep? | Yes | No |
| 14. Are you bothered by pain while trying to fall asleep? | Yes | No |
| 15. Have you ever felt paralyzed when falling asleep? | Yes | No |
| 16. Have you experienced vivid dream-like episodes or scenes when falling asleep? | Yes | No |
| 17. Do you get out of bed and leave the room when having difficulty getting to sleep? | Yes | No |
| 18. Do you use any medication or other sleep aids to help you sleep? If yes, list below. | Yes | No |

Sleep and Waking

- | | | | | | |
|--|------------|-------------|--------------|----------------|-----------|
| 1. Do you snore when you sleep? | | | | Yes | No |
| 2. Is your snoring heard outside the bedroom? | | | | Yes | No |
| 3. If you snore, please circle which positions: | All | Back | Sides | Stomach | |
| 4. Do others complain about your snoring? | | | | Yes | No |
| 5. How many nights per week does your snoring occur? | | | | _____ | |
| 6. Have you been told you stop breathing at night? | | | | Yes | No |
| 7. How many nights per week do these pauses occur? | | | | _____ | |
| 8. If you stop breathing, please circle which positions: | All | Back | Sides | Stomach | |
| 9. Do you move or thrash around frequently at night? | | | | Yes | No |
| 10. Have you been told you kick or move every 20-40 seconds while sleeping? | | | | Yes | No |
| 11. Have you ever injured yourself or others during sleep? | | | | Yes | No |
| 12. Have you been told that you talk in your sleep? | | | | Yes | No |
| 13. Have you been told you arouse from sleep confused or frightened? | | | | Yes | No |
| 14. Have you been told that you sleepwalk? | | | | Yes | No |
| 15. Have you ever found yourself eating at night or found evidence of this in the morning? | | | | Yes | No |
| 16. Have you been told you act out your dreams? | | | | Yes | No |
| 17. Does your bed partner or pet interfere with your sleep quality? | | | | Yes | No |
| 18. Do you wake up feeling paralyzed? | | | | Yes | No |
| 19. Do you experience vivid dream-like episodes or scenes upon awakening? | | | | Yes | No |

Do you awaken from sleep with any of the following: (please circle)

- | | | | | | |
|------------|---------------------|----------------|------------|--------------------|-----------------|
| Dry Mouth | Nasal congestion | Headache | Heartburn | Sweating | Need to Urinate |
| Nightmares | Choking and gasping | Teeth Grinding | Body Aches | Un-refreshed Sleep | Leg Discomfort |
| Reflux | Chest Pain | Cough | Seizures | Environment Noise | Panic Attacks |

Other (please list):

Medical History (circle all that apply)

- | | | | | | |
|-------------|----------------|---------------|------------------|------------|---------------------|
| Allergies | CHF | Seizures | Sinus Problems | Diabetes | High Blood Pressure |
| COPD | Stroke | Tonsillectomy | Eating Disorders | Depression | Thyroid disorders |
| Head Injury | Teeth Grinding | Narcolepsy | Allergies | | |

List any other significant medical history or surgeries: