

## Patient Sleep Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: now \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_

Referred by:  Dr. \_\_\_\_\_  Self  Partner  Other \_\_\_\_\_

What is your main concern about your sleep?

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How long has this been a problem? \_\_\_\_\_ weeks / months / years

How do the symptoms affect your daily life?

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What kind of treatment have you had so far?

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### **Sleep Schedule**

When do you go to bed? Workdays \_\_\_\_\_ Weekends \_\_\_\_\_

How soon do you fall asleep? \_\_\_\_\_ How many times do you wake up from sleep? \_\_\_\_\_

What seems to wake you up? \_\_\_\_\_

How long does it take to fall back to sleep? \_\_\_\_\_

When do you wake up in the morning? \_\_\_\_\_ Do you need an alarm to wake you? \_\_\_\_\_

When do you GET up in the morning? \_\_\_\_\_

Do you feel refreshed or well rested when you wake up? \_\_\_\_\_

Do you take naps? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

What medications, herbs, teas, etc. do you take to help you sleep? \_\_\_\_\_



**Please check all that are true for you.**

- I have been told that I snore.
- I have been told that I stop breathing while I sleep.
- I have high blood pressure.
- I'm often grumpy and irritable.
- I wish I had more energy.
- I get morning headaches.
- I often wake up gasping for breath.
- I often feel sleepy and struggle to remain alert during the day.
- I frequently wake up with a dry mouth.
- I have difficulty falling asleep.
- Thoughts race through my mind and prevent me from getting to sleep.
- I expect a problem with sleep several times a week.
- I often wake up and have trouble going back to sleep.
- I worry about things and have trouble relaxing.
- I wake up earlier in the morning than I would like to.
- I lie awake for half an hour or more before I fall asleep.
- I often feel sad or depressed because I can't sleep.
- I have trouble concentrating at work or school.
- When I laugh, I feel like my muscles are going limp.
- I have fallen asleep while driving.
- I often feel like I am in a daze.
- I have experienced vivid dreams or hallucinations upon falling asleep or awakening.
- I have fallen asleep in social settings such as movies or at a party.
- I start to dream soon after falling asleep or during naps.
- I have "sleep attacks" during the day no matter how hard I try to stay awake.
- I sometimes feel paralyzed just on awakening.
- I wake up at night with an acid/sour taste in my mouth.
- I wake up at night coughing, choking or wheezing.
- I have frequent sore throats.
- I have heartburn at night.
- I have noticed or been told that I kick and jerk during sleep.
- I experience an aching or crawling sensation in my legs.
- I experience leg pain or cramps at night.
- Sometimes I can't keep my legs still; I just have to move them to feel comfortable.
- I have troubling dreams.
- I sleepwalk.
- I talk in my sleep.
- I eat in my sleep.
- I act out my dreams.
- I have hurt myself or others, when I was asleep.



## Sleep Environment

Do you sleep:

Alone  With someone in the same room  With someone in the same bed

Has there been a change in your sleeping arrangements recently? (Because of death, divorce, illness or other reasons?) \_\_\_\_\_

In what size and type of bed do you sleep? \_\_\_\_\_ Is it comfortable? \_\_\_\_\_

Is your bedroom cool? \_\_\_\_\_ Quiet? \_\_\_\_\_ Dark? \_\_\_\_\_

Is your sleep disturbed because of your bed partner, others in your household or pets? \_\_\_\_\_

Besides sleeping, what other activities do you do in the bedroom?

Watch TV  Read  Eat  Do paperwork  Exercise  Other \_\_\_\_\_

## Habit History

How much of each of the following do you drink each day?

Caffeinated Coffee \_\_\_\_\_ cups What time of day? \_\_\_\_\_

Caffeinated Tea \_\_\_\_\_ cups What time of day? \_\_\_\_\_

Caffeinated Sodas \_\_\_\_\_ cups What time of day? \_\_\_\_\_

Alcoholic Beverages \_\_\_\_\_ glasses More on weekends? \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_ Cigars? \_\_\_\_\_ Pipe? \_\_\_\_\_

How many years have you smoked? \_\_\_\_\_ When did you quit? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

What time of day? \_\_\_\_\_ How often? \_\_\_\_\_

## Personal Medical History

*Please check any conditions that you have had.*

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Depression             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Easy bleeding/bruising | <input type="checkbox"/> Menopause           | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Parkinson's Disease | _____                                    |
| <input type="checkbox"/> COPD       | <input type="checkbox"/> Headaches              | <input type="checkbox"/> PMS                 | _____                                    |
| <input type="checkbox"/> CHF        | <input type="checkbox"/> Head Trauma            | <input type="checkbox"/> Reflux              | _____                                    |



*Please list any surgeries, hospitalizations, or serious injuries you have had.*

**Type**

**Year**

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## **Medication History**

*Please list all medications you are currently taking. Include prescription, over the counter, and herbal medications as well as vitamins and nutritional supplements.*

**Medication**

**Strength**

**How often taken**

**Reason**

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Are you allergic to any medications? Please list. \_\_\_\_\_

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## **Social History**

Where were you born? \_\_\_\_\_

Where else have you lived? \_\_\_\_\_

Are you  Single  Married  Separated  Divorced  Widowed  Cohabit

Other

Who lives in the same home with you?

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What is your occupation? \_\_\_\_\_

Work Schedule: \_\_\_\_\_



Commute Times: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

### Family Medical History

	<i>Living</i>	<i>Deceased</i>	<i>Age Now or at Death</i>	<i>Current or Cause of Death</i>	<i>Health</i>
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Are there any conditions or diseases that commonly run in your family? \_\_\_\_\_ If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does anyone in your family have a history of any of the following?

<i>Condition</i>	<i>Who?</i>	<i>Condition</i>	<i>Who?</i>
<input type="checkbox"/> Snoring	_____	<input type="checkbox"/> Restless Legs Syndrome	_____
<input type="checkbox"/> Apnea	_____	<input type="checkbox"/> Extreme Sleepiness	_____
<input type="checkbox"/> Narcolepsy	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/>	_____



## 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. Use the following scale to choose the **most appropriate number** for each situation.

- 0 = would **never** doze
- 1 = **slight** chance of dozing
- 2 = **moderate** chance of dozing
- 3 = **high** chance of dozing

<i>Situation</i>	<i>Chance of Dozing</i>
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 with someone.....	_____
Sitting quietly after a lunch without alcohol .....	_____
In a car, while stopped for a few minutes in traffic .....	_____



**To Patient: Please give this page to someone who has watched you while you sleep.**

Helpful Observer's Questionnaire

Where do you usually sleep in relation to the patient?

- Same house
- Same room
- Same bed

How often have you observed this person's sleep?

- Once or twice
- Often
- Every night

*Please check any of the following behaviors that you have observed the patient do while she/ he is asleep.*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Light snoring                  | <input type="checkbox"/> Twitching or kicking of the legs   | <input type="checkbox"/> Head rocking or banging |
| <input type="checkbox"/> Loud snoring                   | <input type="checkbox"/> Twitching or jerking of the arms   | <input type="checkbox"/> Bed wetting             |
| <input type="checkbox"/> Pauses in breathing            | <input type="checkbox"/> Sitting up in bed not awake        | <input type="checkbox"/> Eating while asleep     |
| <input type="checkbox"/> Occasional loud snorts         | <input type="checkbox"/> Getting out of bed but not awake   | <input type="checkbox"/> Talking while asleep    |
| <input type="checkbox"/> Gasping for air                | <input type="checkbox"/> Awakening with pain                | <input type="checkbox"/> Grind or clench teeth   |
| <input type="checkbox"/> Choking                        | <input type="checkbox"/> Hitting or punching                |  |
| <input type="checkbox"/> Crying out                     | <input type="checkbox"/> Becoming very rigid and/or shaking |  |
| <input type="checkbox"/> Other -- please describe _____ |   |  |

Describe the behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, its frequency during the night, and whether it occurs every night.

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Has this person ever fallen asleep during normal daily activities or in a dangerous situation? \_\_\_\_  
If yes, please explain: \_\_\_\_\_

Please include other information that might be useful to the center in trying to help this patient.

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