

Sleep History

Patient Name:			DOB:	Age:
Gender:	Height:	Weight:	Neck Circumference:	
Telephone:		E-Mail Address:		
Primary Physician:				
Today's Date:			Insurance Name:	

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 sleep schedule? Yes No
- Do you have a regular work 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much per day?
Did you ever use Tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much per day?
Do you eat/drink caffeine? (Chocolate, soda, coffee, tea, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much per day?
Do you consume alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much per day?
Do you exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 has ever complained about your sleep habits? Yes No
- Have any of your family members been diagnosed with a sleep disorder? Yes No
- Do you have any materials allergies (tape, latex, metal, etc.)? Yes No

Daytime Symptoms

1. Do you frequently feel sleepy or fatigued during the day? Yes No
2. Do you frequently have the urge to take naps during the day? Yes No
3. If the opportunity were given, would you be likely to take a nap during a routine day? Yes No
4. Do you routinely feel like taking naps after arriving home from work? Yes No
5. Have you ever had accidents or near accidents due to sleepiness or fatigue? Yes No
6. Do you often feel the urge to fall asleep before noon if not active? Yes No
7. Do you frequently feel the urge to fall asleep during active tasks before noon? Yes No
8. Do you usually feel sleepiness after lunch or other meals? Yes No
9. Do you regularly feel the urge to fall asleep in the afternoon if you are not active? Yes No
10. Do you often feel the urge to fall asleep during active tasks in the afternoon? Yes No
11. Have you ever fallen asleep or started to doze off while driving? Yes No
12. Have you ever fallen asleep or started to doze while at work or school? Yes No
13. Has sleepiness or fatigue ever interfered with your work, home, or social activities? Yes No
14. Do you regularly feel rested when waking up in the morning? Yes No
15. Have you ever found 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 frequently have pain or headaches during the day? Yes No
19. Do you regularly have difficulty concentrating or performing repetitive tasks during the day? Yes No
20. Do you often 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	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Watching TV	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting in a public place (i.e., theater or a meeting)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
As a passenger in a car for an hour without a break	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting and talking to someone	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting quietly after a lunch without alcohol	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

Total _____

Falling Asleep

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

Sleep and Waking

1. Have you ever been told or suspect that you snore when you sleep? Yes No
2. Is your snoring heard outside the bedroom? Yes No
3. If you snore, please check 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 ever been told or suspect that you stop breathing at night? Yes No
7. How many nights per week do these pauses occur?
8. If you stop breathing, please check which positions: **All** **Back** **Sides** **Stomach**
9. Have you ever been told or suspect that you move or thrash around frequently at night? Yes No
10. Have you ever 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 ever been told that you talk in your sleep? Yes No
13. Have you ever been told you arouse from sleep confused or frightened? Yes No
14. Have you ever been told or suspect 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 ever been told or suspect you act out your dreams? Yes No
17. Does your bed partner or pet frequently interfere with your sleep quality? Yes No
18. Have you ever felt paralyzed upon awakening? Yes No
19. Have you ever experienced vivid dream-like episodes or scenes upon awakening? Yes No

Do you awaken from sleep with any of the following: (check all that apply)

- | | | | | |
|---|--|--|---|-------------------------------------|
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Headache | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Need to Urinate | <input type="checkbox"/> Choking and gasping | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Body Aches |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Leg Discomfort | <input type="checkbox"/> Reflux | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Environment Noise | <input type="checkbox"/> Panic Attacks | | |
| <input type="checkbox"/> Other (please list): | | | | |

Medical History (check all that apply)

- | | | | | | |
|--------------------------------------|----------------------------------|--|---|--------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> CHF | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bruxism | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Iron Deficiency | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cardiac Arrhythmias |

List any other significant medical history or surgeries: