Valley Sleep Center
A Night and Day Difference!

PHONE: (480) 830-3900
FAX: (480) 830-3901
valleysleepcenter.com

Patient Name:
DOB:

Sleep History Questionnaire

Briefly describe your primary sleep complaint/problem:

Do the sleep complaints you listed above worsen in high attitude? ☐ **Yes** ☐ **No**

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

When? _____ 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:

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**

Have you used any medication or sleep aids to help you sleep? ☐ **Yes** ☐ **No**

What Sleep Aids have you attempted to use?

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**

Are you on a diet? ☐ **Yes** ☐ **No**

Has your weight fluctuated recently or been an issue in the past? ☐ **Yes** ☐ **No**

How much weight have you lost _____ or gained _____ in the last year?

Do you use alcohol, caffeine, or exercise during the last 4 hours before your bedtime? ☐ **Yes** ☐ **No**

Do you have any materials allergies (tape, latex, metal, etc.)? ☐ **Yes** ☐ **No**

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Do you Smoke?	☐ **Yes** ☐ **No**	How much per day?
Are you a former Smoker?	☐ **Yes** ☐ **No**	
Do you use Tobacco products?	☐ **Yes** ☐ **No**	How much per day?
Have you ever used Tobacco products?	☐ **Yes** ☐ **No**	How much per day?
Do you consume alcohol?	☐ **Yes** ☐ **No**	How much per day?
How many times in the past year have you had 5 (for men) or 4 (for women and any adult over 65 years old) or more alcoholic drinks in a DAY?		
Do you eat/drink caffeine products?	☐ **Yes** ☐ **No**	How much per day?

Daytime Symptoms

Do you frequently feel sleepy or fatigued during the day?	☐ **Yes** ☐ **No**
Do you frequently have the urge to take naps during the day?	☐ **Yes** ☐ **No**
If the opportunity were given, would you be likely to take a nap during a routine day?	☐ **Yes** ☐ **No**
Do you take naps during your day?	☐ **Yes** ☐ **No**
Have you ever had accidents or near accidents due to sleepiness or fatigue?	☐ **Yes** ☐ **No**
Do you often feel the urge to fall asleep before noon if not active?	☐ **Yes** ☐ **No**
Do you frequently feel the urge to fall asleep during active tasks before noon?	☐ **Yes** ☐ **No**
Do you usually feel sleepiness after lunch or other meals?	☐ **Yes** ☐ **No**
Do you regularly feel the urge to fall asleep in the afternoon if you are not active?	☐ **Yes** ☐ **No**
Do you often feel the urge to fall asleep during active tasks in the afternoon?	☐ **Yes** ☐ **No**
Have you experienced “drowsy driving” while operating a motor vehicle?	☐ **Yes** ☐ **No**
Have you ever fallen asleep while operating a motor vehicle?	☐ **Yes** ☐ **No**
Has sleepiness or fatigue ever interfered with your work, home, or social activities?	☐ **Yes** ☐ **No**
Do you regularly feel rested when waking up in the morning?	☐ **Yes** ☐ **No**
Have you ever found yourself performing routine activities and/or driving without thinking?	☐ **Yes** ☐ **No**
Have you ever gone about performing a task only to find you have already done it?	☐ **Yes** ☐ **No**
During strong emotions have you ever felt physical weakness or even fallen?	☐ **Yes** ☐ **No**
Do you frequently have morning headaches?	☐ **Yes** ☐ **No**
Do you regularly have difficulty concentrating or performing repetitive tasks during the day?	☐ **Yes** ☐ **No**
Do you often have the urge to move your legs or have “restless legs”?	☐ **Yes** ☐ **No**

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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

Are you routinely unable to fall asleep in 15 minutes or less?	☐ **Yes** ☐ **No**
Do you regularly wake up many times while trying to fall asleep?	☐ **Yes** ☐ **No**
Do you routinely have thoughts racing through your mind while trying to fall asleep?	☐ **Yes** ☐ **No**
Do you frequently watch a clock while trying to sleep?	☐ **Yes** ☐ **No**
Do you use Electronic Devices/TV to help you fall asleep?	☐ **Yes** ☐ **No**
Do you routinely use “white noise” (fans, sound machines, etc) to help you fall asleep?	☐ **Yes** ☐ **No**
Do you often have anxiety, which keeps you from sleeping?	☐ **Yes** ☐ **No**
Do environmental sounds and/or pets routinely keep you from getting to sleep quickly?	☐ **Yes** ☐ **No**
Do you routinely stay up late and feel you could sleep late in the morning?	☐ **Yes** ☐ **No**
Do you routinely go to bed early only to find yourself waking early in the morning?	☐ **Yes** ☐ **No**
Do you frequently experience achy feelings in your legs, which make you want to move?	☐ **Yes** ☐ **No**
Do you frequently have muscle tension and/or pain which disrupts your ability to fall asleep?	☐ **Yes** ☐ **No**
Have you ever experienced vivid dream-like episodes or scenes when falling asleep?	☐ **Yes** ☐ **No**
Do you usually get out of bed and leave the room when having difficulty getting to sleep?	☐ **Yes** ☐ **No**

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Sleep and Waking

Have you ever been told or suspect that you snore when you sleep?	☐ **Yes**	☐ **No**
Is your snoring heard outside the bedroom?	☐ **Yes**	☐ **No**
Do others complain about your snoring?	☐ **Yes**	☐ **No**
Have you ever been told or suspect that you stop breathing at night?	☐ **Yes**	☐ **No**
Have you ever been told or suspect that you move or thrash around frequently at night?	☐ **Yes**	☐ **No**
Have you ever been told you kick or move every 20-40 seconds while sleeping?	☐ **Yes**	☐ **No**
Have you ever injured yourself or others during sleep?	☐ **Yes**	☐ **No**
Have you ever been told that you talk in your sleep?	☐ **Yes**	☐ **No**
Have you ever been told you arouse from sleep confused or frightened?	☐ **Yes**	☐ **No**
Have you ever been told or suspect that you sleepwalk?	☐ **Yes**	☐ **No**
Have you ever found yourself eating at night or found evidence of this in the morning?	☐ **Yes**	☐ **No**
Have you ever been told or suspect you act out your dreams?	☐ **Yes**	☐ **No**
Does your bed partner or pet frequently interfere with your sleep quality?	☐ **Yes**	☐ **No**
Have you ever had full body paralysis upon awakening?	☐ **Yes**	☐ **No**
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)

☐ Dry Mouth	☐ Nasal congestion	☐ Headache	☐ Heartburn	☐ Sweating
☐ Need to Urinate	☐ Choking and gasping	☐ Nightmares	☐ Teeth Grinding	☐ Body Aches
☐ Un-refreshed Sleep	☐ Leg Discomfort	☐ Reflux	☐ Chest Pain	☐ Cough
☐ Seizures	☐ Environment Noise	☐ Panic Attacks	☐ Other (please list):_____	

Medical History (click all that apply)

☐ Acid Reflux	☐ Eating Disorders	☐ Pneumothorax
☐ Allergies	☐ Head Injury	☐ Pulmonary Hypertension
☐ Anxiety	☐ Heart Attack	☐ Seizures
☐ Arthritis	☐ High Blood Pressure	☐ Sinus Problems
☐ Cardiac Arrhythmias	☐ High Cholesterol	☐ Sleep Apnea
☐ CHF	☐ Insomnia	☐ Stroke
☐ Chronic Pain	☐ Iron Deficiency	☐ Teeth Grinding
☐ COPD	☐ Kidney Disease	☐ Thyroid disorders
☐ Depression	☐ Narcolepsy	☐ Tonsillectomy
☐ Diabetes	☐ Obesity	

List any other significant medical history or surgeries: