SLEEP MEDICINE SERVICES
Featuring Home Sleep Testing
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SLEEP HISTORY

***These questions should be answered by you keeping in mind the following*:**

a) Answer them in relation to the last month, unless otherwise specified
b) A "weekday" should be thought of as any day that you routinely work
c) If you are engaged in shift work or have any type of unusual sleep/wake schedule, "day" and "night" should be interpreted as your major wake and sleep periods respectively.

_____ _____

NAME **DATE**

My main sleep complaint involves (mark all that apply and describe):

☐ trouble sleeping at night ☐ being sleepy all day ☐ unwanted behaviors during sleep (explain below) ☐ other

Please describe your sleep problem(s): _____

_____

_____

_____

My sleep/wake problem began (date and details): _____

_____

_____

Previous sleep tests (when and where) _____

_____

What have you done to treat your problem? _____

_____

I hope the Sleep consultation/visit will help me by: _____

_____

SLEEP DISORDERS QUESTIONNAIRE

Name _____ DOB ____/____/_____ Weight _____ lbs Date _____

Please rate your current (now or within the last week) symptoms (how you feel) by **circling number 1 to 7** that most closely describes the degree or the frequency that you are bothered by a particular complaint or problem.

1	2	3	4	5	6	7
None or Never	Very Slight or Rarely	Slight or Seldom	Moderate or Occasionally	Major or Often	Great or Very Often	Very Great or Always

1) 1 2 3 4 5 6 7 How often do you fall asleep during the day when you are still or not busy?

2) 1 2 3 4 5 6 7 How often do you awaken feeling unrested even after adequate hours of sleep?

3) 1 2 3 4 5 6 7 How often do you suffer from unexplained fatigue or tiredness during the day?

4) 1 2 3 4 5 6 7 How often do you awaken feeling really sleepy or groggy?

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5) 1 2 3 4 5 6 7 How great of a problem do you have with snoring?

6) 1 2 3 4 5 6 7 How often has a bed partner noted you stop breathing during sleep?

7) 1 2 3 4 5 6 7 How often is your sleep disturbed by other breathing problems? (Describe: _____)

8) 1 2 3 4 5 6 7 Do you suffer from headaches on awakening?

9) 1 2 3 4 5 6 7 How often do you awaken from heartburn or stomach acid in the mouth?

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10) 1 2 3 4 5 6 7 How great of a problem do you have getting to sleep?

11) 1 2 3 4 5 6 7 How often do you wake up and have trouble falling back to sleep?

12) 1 2 3 4 5 6 7 How much do you toss and turn during your sleep?

13) 1 2 3 4 5 6 7 How often has a bed partner noted that your legs twitch or kick in you sleep?

14) 1 2 3 4 5 6 7 How often are you trouble by restless or "creepy" legs in the evening or night?

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15) 1 2 3 4 5 6 7 How often do you feel completely paralyzed or "stuck" when just falling asleep or waking up?

16) 1 2 3 4 5 6 7 How often do you hallucinate people, voices, or sounds in the room when just falling asleep or when just awakening?

17) 1 2 3 4 5 6 7 How often during the day do you have episodes of sudden muscular weakness when laughing, angry, or in other emotional situations?

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18) 1 2 3 4 5 6 7 How often do you have unusual behaviors in your sleep? (Circle type(s) of sleep behavior: walking, screaming out, nightmares, violence, eating, confusion, _____, _____).

19) 1 2 3 4 5 6 7 How much does your current sleep problem affect your family life?

20) 1 2 3 4 5 6 7 How much does your current sleep problem affect your work performance?

21) 1 2 3 4 5 6 7 How much does you current sleep problem affect you sense of well being?

22) 1 2 3 4 5 6 7 How often is your sleep disturbed by other problems? (Describe below).

Comments: _____

Try to be specific with the following questions. Please rate your answer based on your average night.

23) What is your work schedule? Days: M T W Th F Sa Su NA Hours: _____ am / pm; to_____ am / pm

24) What time do you usually go to bed? _____ am / pm

25) What time do you usually arise for the day? _____ am / pm

26) How long does it usually take you to fall asleep after deciding to go to sleep? _____ minutes

27) How many times do you wake up during a typical night? _____ times

28) What are the total hours of sleep that you usually get a night?
(Do not include the time you spend awake in bed at night). ____hours. ____minutes

Name: _____ Date: _____

MEDICAL HISTORY

Height _____ inches Current Weight _____ lbs What is your maximum weight ever? __ __ __ __ lbs

In the last 12 months, how many pounds have you (circle appropriate term) gained or lost? _____

Do you smoke tobacco?…… yes, currently no, quit no, never

If yes, how much do you consume per day: cigarette packs/d other

If quit, how long has it been since you stopped? years

List the amounts of what you consume regularly (per day or week)

	Daily	After 6 pm	Weekly
Caffeinated products			
Coffee, cups	_____	_____	_____
Tea (cups/glasses)	_____	_____	_____
Soft drinks (cans/drinks)	_____	_____	_____
Beer, wine, liquor (cans/glasses/drinks)	_____	_____	_____

Past and Current Health Problems	**Type of Problem/Treatment**	**Date of Onset**	**Physician or Facility**
Respiratory Conditions (asthma, COPD, etc.):			
Eyes, Ears, Nose, Throat/Mouth (glaucoma, Sinus, obstruction, allergies, surgery, etc.):			
Heart, Circulation, Blood Pressure:			
Head/Nervous System (e.g. head trauma, Convulsions, stroke):			
Psychological or Psychiatric Disorders:			
Stomach, Digestive, Intestinal Disorders:			
Kidney, Urological or Sexual Disorders:			
Arthritis, other musculoskeletal conditions, related chronic pain			
Metabolic/Hormonal Disorders, (diabetes, thyroid, etc.)			
Surgical Operations, (e.g. tonsillectomy, nasal surgery, hysterectomy, etc.):			

Name: _____ Date: _____

REVIEW of SYSTEMS Circle any of these symptoms/problems that are current concerns:
Headache Seizure Stroke Balance Mobility Strength Vision Hearing Nasal Allergies Other allergies
Sinus Infection Nasal Obstruction TMJ pain Dental Voice Cough Short breath Chest pain High blood pressure
Heart disease Congestive heart failure Edema (swollen extremities) Swallowing Indigestion Heartburn Liver disease
Diarrhea Prostate problem Kidney Disease Menopause Arthritis Muscle disease Osteoporosis Fibromyalgia
Chronic skin condition Diabetes Thyroid Other Hormonal Chronic pain Cancer Weight loss Depression Anxiety
Other psychiatric

Please list all medication (prescription or OTC) used now or in the past for sleep:

MEDICATION FOR SLEEP	**Dose**	**Times daily**		**Use now?**		**Provider**	

Please list all other medications that you are currently taking (or provide a list):

CURRENT MEDICATION	**Dose**	**Times daily**	**AM/PM**	**Provider**	

Please list any medication you are Allergic to and what kind of reaction you have.

MEDICATION	**REACTION**

Name: _____ Date: _____

FAMILY HEALTH HISTORY: For blood relatives, indicate gender, vital status, major health problems, and any sleep disorder; for aunts, uncles, cousins only record conditions that may affect you.

	Living or Deceased	**Major Health Problem**	**Sleep Disorder**
Father			
Mother			
Brothers/			
Sisters			
Children			
Grandparents/ Aunts & Uncles/ Cousins			

Primary Care Physician

Name: _____

Address: _____

_____

_____

Referring Physician
(if not your Regular Physician)

_____

_____

_____

_____

Use the space below for additional comments that you may wish to make.

_____

_____

_____

_____

_____

Name: _____ Date: _____

EPWORTH SLEEPINESS SCALE

In Contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (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

Situation	**Chance of Dozing**
Sitting & Reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____