TREASURE COAST SLEEP DISORDERS, LLC

Sleep History Questionnaire

Name ____ Date____________
(first) (middle) (last)

Address ____

____

Phone: Home ______________________ Work ____________________________

Cell ______________________ Other ____________________________

Date of Birth______________ Age_________ Height _________ Weight _________

Referring Physician:____

Social Security #: ____

Occupation: ___________________________ Marital Status: _____________________

How did you hear about our sleep center?

_____ Physician _____ Relative _____ Friend _____ Newspaper

_____ Magazine _____ Television _____ Radio _____ Seminar

_____ Other

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. It may be helpful to consult your bed partner for his or her observations of your sleep habits and behaviors.

This information will be held in the strictest confidence.

1. Describe your main problem(s) in your own words including when and how this began and what treatment you have received for this in the past.

____
____
____
____
____

2. How often does this problem occur?

( ) almost every night
( ) for periods of at least one week
( ) irregularly
( ) other ____.

3. How long has this problem bothered you?

( ) longer than 2 years
( ) 1 to 2 years
( ) several months
( ) within the last 3 months
( ) within the last month

4. On the scale below, please estimate the severity of your problem(s).

________ Mildly Upsetting	________ Moderately Severe	________ Very Severe	________ Extremely Severe	________ Totally Incapacitating

5. How do you describe your sleep problem? Check all that apply to you.

( ) difficulty falling asleep
( ) wake up early in the morning
( ) difficulty awakening
( ) wake up during the night
( ) excessive daytime sleepiness

6. Do any members of your family have sleep problems? Please explain.

____
____
____
____

7. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

( ) general practitioner
( ) cardiologist
( ) other internist
( ) obstetrics/gynecologist
( ) other physician
( ) clinical psychologist
( ) chiropractor
( ) osteopath
( ) nutritionist
( ) counselor
( ) social worker
( ) psychiatrist
( ) other:______________________________

8. What treatments have you received?

____
____
____
____
____
____
____
____
____

9. Please rate how often you:

	Never	Rarely	Sometimes	Frequently	Constantly
Awaken from sleep short of breath	____	____	____	____	____
Awaken at night with heartburn, belching or cough	____	____	____	____	____
Snore	____	____	____	____	____
Snore loudly enough that others Complain	____	____	____	____	____
Have trouble sleeping when you have a cold	____	____	____	____	____
Suddenly wake up gasping for breath during the night	____	____	____	____	____
Have breathing problems at night observed by self or others	____	____	____	____	____

	Never	Rarely	Sometimes	Frequently	Constantly
Sweat excessively at night	____	____	____	____	____
Notice your heart pounding or beating irregularly during night	____	____	____	____	____
Fall sleep during the day	____	____	____	____	____
Fall sleeping involuntarily	____	____	____	____	____
Fall asleep while driving	____	____	____	____	____
Fall asleep during physical effort	____	____	____	____	____
Fall asleep while laughing or crying	____	____	____	____	____
Experience loss of muscle tone when extremely emotional	____	____	____	____	____
Have trouble at school or work because of sleepiness	____	____	____	____	____
Feel unable to move (paralyzed) when waking or falling asleep	____	____	____	____	____
Feel afraid of going to sleep	____	____	____	____	____
Have nightmares	____	____	____	____	____
Remember your dreams	____	____	____	____	____
Have thoughts racing through your mind	____	____	____	____	____
Feel sad and depressed	____	____	____	____	____
Have anxiety (worry about things)	____	____	____	____	____
Have muscular tension	____	____	____	____	____
Notice parts of your body jerk	____	____	____	____	____
Kick during the night	____	____	____	____	____

	Never	Rarely	Sometimes	Frequently	Constantly
Experience crawling and Aching feelings in your legs	____	____	____	____	____
Experience any type of leg Pain during the night	____	____	____	____	____
Have morning jaw pain	____	____	____	____	____
Grind teeth during sleep	____	____	____	____	____
Are you bothered by Pain during the day	____	____	____	____	____
Are you bothered by pain During the night	____	____	____	____	____
Are you awakened by pain During the night	____	____	____	____	____
Wake up feeling stiff in the Morning	____	____	____	____	____
Wake up with sore or achy Muscles	____	____	____	____	____
Wake up with pain in the neck, Spine or joints	____	____	____	____	____

10. Is your present work situation satisfactory?

____

11. **Underline** any of the following at apply to you:

- Headaches
- Palpitations
- Bowel disturbance
- Nightmares
- Feel tense
- Depressed
- Unable to relax
- Don't like weekends and vacations
- Can't make friends
- Can't keep a job
- Financial problems
- No appetite
- Alcoholism
- Take drugs
- Can't make decisions
- Unable to have a good time
- Take antacids regularly (tums, tagemet, etc.)
- Dizziness
- Stomach trouble
- Fatigue
- Take sedatives
- Feel panicky
- Suicidal ideas
- Overambitious
- Memory problems
- Inferiority feelings
- Fainting spells
- Insomnia
- Tremors
- Shy with people
- Home conditions bad
- Concentration difficulties
- Others

12. **Underline** any of the following words that apply to you:

- Worthless
- Inadequate
- "Can't do anything right"
- Morally wrong horrible thoughts
- Anxious
- Panicky
- Lonely
- Restless
- Full of regrets
- Attractive
- Useless
- Stupid
- Agitated
- Aggressive
- Unloved
- Confused
- Worthwhile
- Confident
- a "nobody"
- Incompetent
- Guilty
- Hostile
- Cowardly
- Ugly
- Misunderstood
- Unconfident
- Sympathetic
- Considerate
- "life is empty"
- Naïve
- Evil
- Full of hate
- Unassertive
- Deformed
- Bored
- In conflict
- Intelligent

Others:____

13. Does your sleep problem disturb your sex life?

( ) yes ( ) no

14. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?

____
____
____
____
____
____
____
____
____

15. How many hours of sleep do you usually get per night?_______________

16. What time do you usually get to bed on **weekdays**? _______________
weekends?_______________

17. How long does it take you to fall asleep?_______________

18. How many times do you typically wake up at night?_______________

19. If you do wake up, on the average, how long do you stay awake?_______________
____

20. If you do awaken during the night, during which parts of your sleep do you awaken?____
____

21. What do you usually do when you awaken during the night?_______________
____
____
____

22. What time do you usually awaken in the morning on **weekdays**?_______________
____
weekends?_______________
____

23. On the average, how long do you stay in bed after waking up in the morning?__________
____

24. Do you usually: (check all that apply to you)

( ) Sleep with someone else in your bed
( ) Sleep with someone in your room
( ) Provide assistance to someone during the night (child, invalid, bed partner, animal)

25. Is your sleep often disturbed by:

( ) heat
( ) cold
( ) noise
( ) light
( ) bed partner
( ) not being in your usual bed
( ) other____________________

26. Are your sleep habits on weekends different from the rest of the week?

( ) No
( ) Yes - please describe____________________

____

27. With whom are you now living? (spouse, children, parents, etc. Please list ages).

____
____
____
____
____
____

28. Do you work split shifts or rotating (variable) shifts?____________________

29. Do you usually drink coffee or tea within 2 hours before you go to bed?

( ) yes ( ) no

30. Do you do physical exercise before bedtime?:

( ) yes ( ) no

31. Do you read before falling asleep?

( ) yes ( ) no

32. Do you watch TV in bed before falling asleep?

( ) yes ( ) no

33. Do you take naps during the afternoon or evening?

( ) yes ( ) no

34. Do you feel refreshed after a short (10-15 minute) nap?

( ) yes ( ) no

35. How do you feel after an average night of sleep?

( ) usually drowsy and/or tired
If so, for how long? ( ) one hour ( ) 2 hours ( ) 3 hours
( ) Most of the time good
( ) Consistently good

36. Do you feel better during:

( ) Morning ( ) Afternoon ( ) Evening

37. Do you take any kind of medication?

Name	Amount	How often	Reason

38. List your consumption of the following per day:

Coffee__________ Colas__________
Tea__________ Chocolate__________
Nicotine__________ Alcohol__________
Over the counter drugs__________ Other drugs__________

39. What is your personal interpretation as to why you have your particular sleep/wake problem?

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____
____
____
____
____

40. Please describe any other information pertinent to your sleep or wakefulness not previously described.

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____
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____
____

THE 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 like in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of 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 and reading	________
Watching TV	________
Sitting inactive in a public place (i.e. a theater or meeting)	________
As a passenger in a car without a break	________
Lying down to rest in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________