

SLEEP HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. *Your bed partner may be able to assist you.* This information will become part of your medical record and will remain confidential.

Date questionnaire completed: _____
(Month/Day/Year)

GENERAL INFORMATION:

Name: _____
Last First MI

Address: _____
Street

City State Zip Code

Home: (_____) _____ Work: (_____) _____

Birth Date: ____/____/____ Age: ____ Sex: ____ Race: _____

Height: _____ Weight: _____ Marital Status: _____

SSN: _____ Occupation: _____

Emergency Contact: _____

Phone: _____

Referring Physician: Shirley Nesbit, FNP, Missions Weight Management Institute
Phone: 828-213-4100

N: Never (or No) R: Rarely O: Occasionally F: Frequently A: Always Y: Yes

SUMMARY OF YOUR SLEEP PROBLEM:

1. Describe your sleep problem(s) in your own words.

2. Describe how and when this problem began.

3. Describe any treatments you have received for your problem.

4. Has this been a continuous or intermittent problem?

- intermittent, occasional problem
- frequent problem
- continuous, almost every night

5. How long has your sleep problem bothered you?

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

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MEDICAL HISTORY/CONDITIONS:

6. List current medical conditions for which you are being treated as well as the physician.

7. List all hospitalizations and surgeries you have had (Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions).

Problem or diagnosis

Date

8. List medications you are currently taking. (Please include prescription and non-prescription medications of all types, including sleep and non-sleep and non-sleep related. Also indicate if you are on supplemental oxygen.

Name of medication

Dosage

How often

Reason

9. Please list/describe any allergies you have: _____

10. Do you have family history of snoring or other sleep disorders? N Y

If yes, please describe. _____

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11. Are you unable to sleep in a flat position due to shortness of breath? N Y
12. Have you ever sustained a brain concussion, head injury or serious blow to the head? N Y
13. Do you have spells or seizures? N Y
14. Do you have high blood pressure? N Y
15. Have you experienced weight gain in the last year? N Y
- A: If yes, approximately how many pounds have you gained? _____pounds
16. Has your shirt collar size increased recently? N Y
- A: If yes, approximately how many inches has it increased? _____inches
- 17: Do you smoke? N Y
- A: If so, how many packs per day? _____packs
- B: How long have you smoked? _____years
18. Are you a former smoker? N Y
- A: If you are a former smoker, how much? _____packs
- B: How long did you smoke? _____years
- C: When did you quit smoking? _____
19. Do you drink alcohol? N Y
- A: Please estimate the number of drinks (including beer, wine, liquor) per day. _____workdays
_____days off
- B: Do you drink alcohol after 6:00 p.m.? N R O F A
(Circle the appropriate response. Use abbreviations at top of page.)
20. Do you consume caffeinated drinks? N Y
- A: If you drink caffeinated drinks, please Estimate the number of drinks (including soft drinks, Coffee, tea) you have per day. _____workdays
_____days off

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- B: Do you drink caffeine after 6 p.m.? N R O F A
21. (Males) Have you experienced difficulties with sexual functioning? N R O F A
22. (Females) Does your sleep problem vary according to the stage of your menstrual cycle? N Y
23. (Females) Have you gone through menopause or had a hysterectomy? N Y

YOUR SLEEP HABITS:

24. How many hours of sleep do you usually get per night? _____
25. What time do you usually go to bed? _____workdays
_____days off
26. What time do you usually wake up? _____workdays
_____days off
27. How long does it take you to fall asleep? _____
28. How many times do you typically wake up at night? _____
29. If you wake up, on average how long do you stay Awake? _____
30. Which shift do you work? (Check all that apply) _____day
_____evening
_____night
31. How often do you rotate shifts? N R O F A
32. Does your job require overnight travel? N R O F A
33. Are you able to fall asleep and awaken on a day to Day, week to week basis according to your desired Schedule? N R O F A
34. Do you nap during the day or evening? N R O F A

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THE QUALITY OF YOUR SLEEP:

- | | | | | | | |
|-----|---|---|---|---|---|---|
| 35. | Do you feel refreshed after a typical night's sleep? | N | R | O | F | A |
| 36. | Do you feel sleepy during the day even when you
Have slept all night? | N | R | O | F | A |
| 37. | Do you feel refreshed after a short nap? | N | R | O | F | A |
| 38. | Do you get sleepy while driving? | N | R | O | F | A |
| 39. | Have you had an accident or near-accident when
Driving, due to excessive sleepiness? | N | R | O | F | A |
| 40. | Do you fall asleep when you want to stay awake
(movies, theater, church, or watching television) | N | R | O | F | A |
| 41. | Are you able to fight off the excess sleepiness? | N | R | O | F | A |
| 42. | Do you have memory or concentration problems? | N | R | O | F | A |
| 43. | Do you experience vivid dream-like scenes upon
Awakening or falling asleep? | N | R | O | F | A |
| 44. | When you are angry or laugh, do you ever feel weak,
As though you might fall? | N | R | O | F | A |
| 45. | Are you ever unable to move or speak upon falling
asleep or awakening? | N | R | O | F | A |
| 46. | Do you have trouble falling asleep when you first
Go to bed? | N | R | O | F | A |
| 47. | When you try to fall asleep does your mind race
with many thoughts? | N | R | O | F | A |
| 48. | When you try to fall asleep do you worry about
Whether or not you will be able to sleep? | N | R | O | F | A |
| 49. | When you try to fall asleep do you feel pain? | N | R | O | F | A |
| 50. | Does pain ever wake you up, disrupt your sleep
Or keep you from going back to sleep? | N | R | O | F | A |
| 51. | Are you a light sleeper, easily awakened? | N | R | O | F | A |
| 52. | Is your sleep disturbed because of your bed partner
or others in your household? | N | R | O | F | A |

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- | | | | | | | |
|-----|---|---|---|---|---|---|
| 53. | Do you snore? | N | R | O | F | A |
| 54. | Does your snoring stop for brief periods during the night (as seen by others)? | N | R | O | F | A |
| 55. | Does your breathing sometimes stop during sleep (as seen by others)? | N | R | O | F | A |
| 56. | Is your bed partner disturbed by your snoring? | N | R | O | F | A |
| 57. | Do you wake up choking or gasping for breath? | N | R | O | F | A |
| 58. | Do you have night sweats? | N | R | O | F | A |
| 59. | Do you have heartburn at night? | N | R | O | F | A |
| 60. | Do you have a bitter bile taste in the back of your Throat when you wake up (not “morning breath”)? | N | R | O | F | A |
| 61. | Do you have nasal/sinus congestion at night? | N | R | O | F | A |
| 62. | Do you have morning headaches? | N | R | O | F | A |
| 63. | Are you a restless sleeper, tossing and turning At night? | N | R | O | F | A |
| 64. | Do you have a creeping or crawling sensation In your legs when you lie down to sleep? | N | R | O | F | A |
| 65. | Do you experience any type of leg pain during the night? | N | R | O | F | A |
| 66. | Are you aware of your legs kicking or jerking while you are attempting to sleep? | N | R | O | F | A |
| 67. | Do you grind or clench your teeth during sleep? | N | R | O | F | A |
| 68. | Did you walk or talk in your sleep as a child or Adolescent? | N | R | O | F | A |
| 69. | Do you now walk or talk in your sleep? | N | R | O | F | A |
| 70. | Do you have frightening dreams or nightmares? | N | R | O | F | A |

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71. Do your dreams or nightmares awaken you?

N R O F A

72. Do you wet your bed?

N R O F A

OTHER COMMENTS:

Are there any other aspects of your sleep problem which you feel have not been adequately covered on this questionnaire? If so, please describe below.

The Epworth Sleepiness Scale

Name: _____

Today's Date: _____ Your Age: _____

Your sex (circle one): Male Female

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

Situation

Chance of Dozing

Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater or 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 to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____