SLEEP HISTORY

Date _____ Chart No. _____

Name _____ Date of Birth _____

Marital Status _____ Occupation _____

Home Address _____ Phone Number _____

IT IS VERY IMPORTANT THAT YOU ANSWER EVERY QUESTION EVEN IF YOU ARE UNAWARE OF ANY SLEEP PROBLEMS

1. Why did your doctor refer you for a sleep study?

2. How many nights a week do you have sleep problems? _____ Nights

3. How long have you had these sleep problems? _____ weeks / months / years

4. Please rate the following characteristics of your sleep:
   Bedtime Schedule: Very Consistent / Generally Regular / Irregular / Very Irregular
   Quality of Sleep: Poor / Intolerable / Good / Excellent
   Amount of Sleep: Too Much / Too Little / Sufficient Amount

5. What time do you go to bed during the week? _____ AM/PM
   What time do you get up during the week? _____ AM/PM
   Estimate the number of hours of sleep per night during the week _____ hours

6. What time do you go to bed on the weekends? _____ AM/PM
   What time do you get up on the weekends? _____ AM/PM
   Estimate the number of hours of sleep per night on the weekends _____ hours

7. Are you unable to work because of health? Yes No
   Are you retired from work? Yes No
   Does your employment involve shift work? Yes No
   IF YES: Describe your shiftwork rotation. _____

   The shiftwork rotation I sleep best is when I work _____. In your opinion, what percentage of your sleep problems are related to shiftwork? _____%.

(Answer the remaining Questionnaire using the sleep-wake schedule related to the shift you sleep best)

8. How long does it take you to fall asleep? _____ minutes / hours

9. On the average, how often do you wake up during the night? _____times.
   Do you know why you wake up during the night? Yes No
   If YES, Reason: _____

10. How many days a week do you wake up too early? _____times per week. At what time? _____AM / PM

Although you may not wish to sleep at these times, indicate the hours that your body seems to have chosen to:

a.) fall asleep: _____AM / PM

b.) get up for the day: _____AM / PM

11. How long does it take you to become fully awake in the morning? _____minutes / hours
12. Fill in a number on a scale of 0 to 10 indicating how rested you feel when you awaken for the day with 10 being most rested and 0 being totally unrested: _____

13. Do you get urges to fall asleep during the day? Yes No

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 (rate 0,1,2,3)**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or a 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

14. Do you fall asleep while working at your job? Yes No
Do you have sleep attacks or fall asleep against your will? Yes No
Do you fall asleep while driving your vehicle? Yes No
Do you stop to nap while driving? Yes No
Have you fallen asleep at stop signs or red lights? Yes No
Have you ever had an accident because of falling asleep while operating your vehicle? Yes No

15. Do you nap during the day? Yes No

IF YES:

How often per day? _____, per week? _____ For how long? _____minutes / hours

Are the naps refreshing? Yes No

16. Do you sleep alone? Yes No

IF NO, please chose one of the following:

_____My bed partner is a sound sleeper who is unable to provide much history about my sleep problems

_____My bed partner has been able to provide accurate information for this sleep history

17. Do you snore? Yes No

18. Is your snoring interrupted by worrisome silences, pauses in your breathing or gasping? Yes No

19. Have you been observed to stop breathing for sufficiently long periods during sleep that your family or friends have commented about? Yes No

If YES:
Do you experience gasping as airflow resumes again? Yes No
Do you experience snorting as airflow resumes again? Yes No

20. Have you awakening during the night choking Yes No

21. Do you frequently awaken with a dry mouth in the morning? Yes No

22. Do you sweat a lot while sleeping? Yes No

23. Do you get headaches during your sleep time or after awakening? Yes No

24. Are you a restless sleeper? Yes No

25. Do you kick during sleep? Yes No

26. Do your arms/ legs or body jerk during sleep? Yes No
If yes, does this mainly occur as you are falling asleep or while you are waking up? Yes No

27. Do you have vivid or lifelike dreams?

Are the dreams so vivid or disturbing that they seem like hallucinations? Yes No
Do you see people, animals or lifelike forms in your room while dreaming/ Yes No
Do you jump out of bed or even leave your room because of these dreams? Yes No
Do many of your dreams seem to begin as soon as you fall asleep? Yes No
Do you experience dreaming if you take daytime naps? Yes No

28. Do you frequently have bad dreams or nightmares? Yes No

29. Do you talk or moan in your sleep? Yes No

30. Do you scream or yell in your sleep? Yes No

31. Do you sleepwalk?

Do you go outside your residence while sleepwalking? Yes No
Have you injured yourself or others while sleepwalking? Yes No
Do you eat food as part of your sleepwalking activity? Yes No
Do you operate your vehicle during sleepwalking activity? Yes No

32. Do you have "night terrors"? Yes No
Do you remember your night terror episodes? Yes No

33. Do you or have you ever wet the bed?

IF YES: Have you wet the bed after the age of 18 years? Yes No
At what age did your bedwetting appear? _____ years old
Are you usually dreaming at the time of bedwetting? Yes No
Does bedwetting occur when you drink alcohol? Yes No

34. Do you grind your teeth? Yes No
IF YES: Have you damaged your teeth because of grinding during sleep? Yes No
Do you wear a dental plate for this problem? Yes No

35. Do you have restless feelings in your legs at bedtime? Yes No
IF YES, Tick one or more answers which best describe these "restless" feelings:
- ☐ Crawling feeling like something under the skin
- ☐ Achy feelings
- ☐ Limbs feel asleep with the sensation of pins and needles
- ☐ I am unable to keep my legs still and must move them as I attempt to get relief
- ☐ These restless feelings appear mainly while I am awake and inactive
- ☐ These restless feelings appear when I wake up during the night

How often do these feelings interfere with falling asleep? _____ times, _ per week / month / year.

36. Have you ever felt "paralyzed" as if you were unable to move any part of your body while falling asleep, waking up or coming out of a dream? Yes No

37. Some people lose muscle strength or become very weak during or immediately after experiencing sudden emotion such as laughter, excitement, surprise or anger. This loss of muscle strength may result in behavior such as dropping things, weakness of the facial muscles, having to sit or falling down. Do you ever experience any problems such as these? Yes No

38. Some people do things "automatically" while "awake" that they cannot recall doing later. For example, they may go to another room to carry out some activity and by the time they get there they have forgotten what they were going to do. There may be a lack of concentration or inappropriate behavior, for example a person may put the kettle in the fridge, or may drive to a destination without remembering how they got there. Do you ever experience any such problems? Yes No

39. Do you behave in a violent or aggressive way during sleep? Yes No
IF YES: Have you ever choked your partner during sleep? Yes No
Have you ever injured yourself during sleep related violent activity? Yes No
Have you ever broken any furniture or damaged your bedroom during sleep related violent activity? Yes No

40. Has anyone observed you making unusual movements while asleep? Yes No
IF YES, please describe these unusual movements: _____
_____

41. Do you take medication to sleep better? Yes No
Do you take alcohol to try to sleep better? Yes No

42. Do you have a Family History of Sleep Disorders? Yes No

IF YES: Check one or more of the following choices:

_____ Snoring	_____ Kicking During Sleep
_____ Sleep Apnea	_____ Restless Legs
_____ Excessive Daytime Sleepiness	_____ Insomnia
_____ Narcolepsy	_____ Other Sleep Disorders

MEDICAL HISTORY

Have you ever had a sleep study before? If yes, indicate when and where _____

1. List any drugs or medicines that you are allergic to or to which you have had significant side effects:

2. Do you smoke marijuana or take any other psychotropic drugs? Yes No

3. How many alcoholic drinks do you have on weekdays? _____ / day for _____ weekdays per week

   How many alcoholic drinks do you have on weekends? _____/ day

4. How many caffeine containing drinks do you consume per day?

   Coffee _____ Tea _____ Colas _____ Other caffeine containing drinks _____

5. Do you smoke? Yes No

   If YES How many cigarettes per day? _____

   How many cigars per day? _____

   Do you smoke a pipe? _____

Do you have a history of any of the following illnesses (check all that apply)

_____ High Blood Pressure
_____ Angina
_____ Irregular heartbeats
_____ Swelling of the ankles
_____ Heart failure
_____ Heart attack

_____ Low Blood Pressure
_____ Aneurysm
_____ Heart surgery
_____ Circulation trouble
_____ Heart murmur
_____ Other heart problems

_____ Environmental allergies
_____ Bronchitis Pneumonia
_____ Nose Injury
_____ Sinusitis
_____ Mouth/Throat Ailments
_____ Ear Trouble

_____ Asthma
_____ Other breathing difficulties
_____ Blocked Nasal Passages
_____ False Teeth/Dentures
_____ Eye Problems
_____ Strange breathing sounds in sleep

_____ Change in Appetite
_____ Weight loss
_____ Heartburn, sour taste
_____ Bowel problems

_____ Excessive thirst
_____ Weight gain
_____ Ulcers

_____ Head Injury
_____ Fainting
_____ Seizure activity
_____ Memory problems

_____ Dizzy spells
_____ Frequent headaches
_____ Stroke

_____Kidney disease
_____ Prostate difficulty

_____ Bladder trouble
_____ Sexual problems

Medical history (continued)

_____Arthritis
_____Neck pain
_____ Muscle problems

_____ Back pain
_____ Joint difficulties
_____ Phlebitis

_____ Difficulty relaxing
_____ Nervous exhaustion

_____ Depression problems
_____ Psychiatric treatment

_____ Diabetes mellitus
_____ Anemia
_____ Epilepsy
_____ Jaundice
_____ Alcoholism
_____ Serious disability

_____ Thyroid trouble
_____ Cancer
_____ Rheumatic fever
_____ Liver problems
_____Paralysis
_____ Inability to work now on a medical basis?

Describe any medical problems not mentioned above?

_____

List all your hospitalizations for operations, medical or psychiatric treatment:

Date	Hospital	Reason	Treatment

Give the date of your last Chest X-ray: _____Give the date for your last EKG (Heart Tracing)_____

Family Health History: Tick any diseases that run in your family:

- ☐ Weight Problems
- ☐ High Blood Pressure
- ☐ Heart Attacks or Other Heart Disease
- ☐ Stroke
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Kidney, Bladder Disease
- ☐ Lung Disease
- ☐ Bowel Disease
- ☐ Blood Disease
- ☐ Neurological

Medication Log

Are you currently on any medication? (This includes both prescribed and non-prescribed medications including any vitamins and supplements)

Yes _____ **No** _____

If yes, please list all your current medication. Include any medications taken in the last three weeks both prescription and non-prescription. Note any missed doses within the last three weeks.

On the day of your sleep study, bring any medications that you need to take between 8:15pm and 7am.

Medication Name	**Frequency of Use**	**Time (s) of use**	**Date and Time of any missed dosages**