Patient History

Name: _____

Sex: Male | Female (*circle*) Age: _____ Height (*inches*): _____ Current Weight (*lbs.*): _____

Past Sleep Problems

Have you had a sleeping problem **diagnosed by a doctor** in the past? Yes | No

If yes, what was the problem? Sleep Apnea | Something Else (please specify) _____

If yes, what treatment(s) was/were needed? _____

Did the treatment(s) help? Yes | No

Where was the diagnosis made and about when? _____

Sleep Schedule and Sleep Hygiene

Do you keep a fairly regular sleep/wake schedule? Yes | No If irregular, how much does your bedtime vary over a week? _____

What time do you usually go to bed on week days or days that **you work**? _____ : _____ AM | PM (*circle*)

What time do you usually get up on week days or days that **you work**? _____ : _____ AM | PM (*circle*)

What time do you usually go to bed on weekends or days you **do not work**? _____ : _____ AM | PM (*circle*)

What time do you usually get up on weekends or days you **do not work**? _____ : _____ AM | PM (*circle*)

Do you usually feel well rested upon awakening? Yes | No If not, how do you feel? _____

How many hours do you usually sleep?

Week days or days that **you work** _____ hours

Week days or days that you **don't work** _____ hours

Do you nap during the day? Yes | No

If yes above,	Number of Naps per week	Average Length (Minutes)	Feel Refreshed Afterwards?
Weekdays (Work Days)	_____	_____	Y | N | A Little Better
Weekends (Days Not Working)	_____	_____	Y | N | A Little Better

Do you read in bed? Yes | No

Do you watch TV in bed? Yes | No

Do you frequent look at your bedroom clock at night? Yes | No

Do you have arguments in bed? Yes | No

Do you eat in bed? Yes | No

Do you worry in bed? Yes | No

Do you currently do shift work? Yes | No

Have you done shift work in the past? Yes | No

If yes to the above, 2 questions, do you have trouble sleeping when you are doing shift work? Yes | No

If yes to above, what shift do you work? Second | Third | Rotating (how? _____)

Does your spouse perform shift work? Yes | No

If yes to above, please explain: _____

Do you share your bed with anyone? Yes | No I previously did, but they | I moved to another room | I don't sleep in a bed, I sleep in a _____

If yes to above, please circle any who share your bed.

Spouse/significant other | Pet (What kind? _____) | Children (Ages? _____)

If yes to above, do any of them disturb your sleep? Yes | No If yes, please explain: _____

Please circle any adverse factors in your sleep environment.

Too hot | Too cold | Too much light noise (if so, please explain: _____) | Frequent Interruptions (What? _____)

Bed is uncomfortable (if so, how? _____) | Other Factors: _____

Answer the following questions assuming "night" means your major sleeping time. Ex. If you are a shift worker and sleep during the day "night" = daytime sleep period

Do you often have trouble getting to sleep at night? Yes | No Are you sleepy when you go to bed? Yes | No

What is the average number of minutes it takes you to fall asleep at night? _____ Minutes

If yes to above, please circle any of the following you have.

Can't stop thinking about things | Frequent clock watching | Frustrated over inability to sleep | Sleep better in different environments (on vacation)

Do you think your sleep would be better if you could go to bed later (i.e. 2-3 AM) and wake up later (Noon)? (i.e., Are you a "night owl?") Yes | No

Do you often have awakenings during the night? Yes | No

If yes to above, what is the average number of times per night you wake up? _____ Times per Night

If yes to above, why do you awaken (circle factors below or write out any unlisted)? _____

CIRCLE ANY FACTORS THAT YOU THINK MAY DISTURB OR PREVENT YOUR SLEEP: Pain (Where? _____)

Heartburn Worry Children Leg Kicking / Movements Snoring Choking / Gasping Coughing Night Sweats Hot Flashes

Need to use the bathroom Breathing Difficulties Noises (What? _____) Bedpartner (Snoring, Kicking, etc.) Belly Cramping

On most nights, do you have long periods when you awaken and are not able to get back to sleep? Yes | No

If yes to above, how long are these periods of wakefulness when added together? _____ Minutes per night

Are you bothered by waking up too early and not being able to go back to sleep? Yes | No If yes, what is the number of nights per week? _____

Movement

Do you awaken yourself by kicking your legs, or other sudden movements, during the night? Yes | No

Has your bed partner every complained of your legs kicking, or other sudden movements, during the night? Yes | No

Do you have a vague sense of discomfort or an unpleasant sensation in your legs which is relived **only by getting up, rubbing your legs, or moving**? Yes | No

What time of the day does it typically come on? _____ : _____ AM | PM (*Circle one*)

If yes, does it cause you difficulty with falling asleep? Yes | No

Parasomnias

Did you have a sleep problem as a child? Yes | No

If yes, describe _____

_____

Do you currently have frequent nightmares or night terrors? Yes | No If yes, how frequently? _____ per Week | Month | Year (C*ircle one*)

Do you grind or clench your teeth at night? Yes | No

Do you have morning jaw pain or has your dentist made you a mouthpiece for this? Yes | No

Did you frequently wet the bed as a child? Yes | No

Have you ever wet the bed as an adult? Yes | No

Have you ever been told that you walk in your sleep? Yes | No Have you recently walked in your sleep? Yes | No

Have you ever been told you make unusual movements (i.e., swinging arms about, acting out dreams, etc.) during sleep? Yes | No

Excessive Sleepiness

Do you feel sleepier **than the average person** during the daytime? Yes | No

If yes to above, how long? _____ Months | Years (*Circle one*)

If yes to above, do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes | No

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: **Please put a number value for each circumstance, PLEASE DO NOT GIVE A RANGE**. If you are on treatment, fill this out how you are feeling now. 0 = Would ***never*** doze | 1 = ***Slight*** chance of dozing | 2 = ***Moderate*** chance of dozing | 3 = ***High*** chance of dozing

Sitting and reading	_____	Lying down in the afternoon to rest when circumstances permit	_____
Watching TV	_____	Sitting and talking to someone	_____
Sitting, inactive in a public place	_____	Sitting quietly after a lunch without alcohol	_____
As a passenger in a car for an hour without a break	_____	In a car, while stopped for a few minutes in traffic	_____

Have you ever felt sudden muscle weakness when you laughed, got angry, or when you told a joke? Yes | No

If yes to above, describe _____

Have you ever been unable to move your body just as you were falling asleep or waking up? Yes | No

If yes to above, describe _____

Have you ever had hallucinations just as you were falling asleep or waking up? Yes | No

If yes to above, describe _____

Have you ever had a driving accident or a near miss accident as **a result of falling asleep or feeling sleepy at the wheel**? Yes | No

If yes to above, describe _____

Respiration (If you are on treatment for sleep apnea, fill this out how you are, while using the treatment.)

Have people who have shared (or are sharing) your bedroom told you that you snore?

Never | Rarely (1-2 times per year) | Occasionally (4-8 times per year) | Sometimes (1-2 times per month)

Often (1-2 times per week) | Usually (3-5 times per week) | Always (every night) | I don't know

Duration _____ Months | Years (*Circle* one)

Can your snoring be heard through closed doors or through a wall? Yes | No

Have you been told by other people that you gasp, choke, or snort while you are sleeping?

Never | Rarely (1-2 times per year) | Occasionally (4-8 times per year) | Sometimes (1-2 times per month)

Often (1-2 times per week) | Usually (3-5 times per week) | Always (every night) | I don't know

Have you been told that you stop breathing during sleep? Yes | No

If yes, to how often do you stop breathing during your sleep?

Never | Monthly | Weekly | Daily

Do you wake up with morning headaches? Yes | No

Never | Monthly | Weekly | Daily

Do you have bloodshot eyes with these headaches? Yes | No

Do you awaken with a dry mouth or sore throat?

Never | Monthly | Weekly | Daily

Do you wake with a choking or gasping sensation or awaken your self-snoring?

Never | Monthly | Weekly | Daily

Do you have **drenching** night sweats (drench pillow or sheets)? Yes | No

Does sleep position affect your snoring? Yes | No

If yes to above, in which sleep position do you snore most loudly (*pick one*)?

Back | On right side | On left side | Stomach | Other

Do you have, difficulty breathing through your nose? Yes | No

If yes to above, please describe and circle any associated symptoms you have.

Nasal Stuffiness | Runny Nose | Itchy Eyes / Ears | Runny nose around smoke / strong smells / perfumes | Allergies

Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)? Yes | No

If yes to above, please describe _____ When? _____

Have you had any weight loss surgery? Yes | No

If yes to above, please describe _____ When? _____

Please recall your weight history: (*N/A, if not applicable.*)

Weight at age 20 _____ lbs Weight at age 50 _____ lbs Heaviest Weight _____ lbs

Weight at age 30 _____ lbs Weight at age 60 _____ lbs Age at heaviest weight _____

Weight at age 40 _____ lbs Weight at age 70 _____ lbs

Have you attempted to diet? Yes | No

Have you tried weight loss medications? Yes | No

Medications and Drugs (Fill this out only if we do not have your medication list.)

Do you have any allergies or adverse reactions to medications? Yes | No

If yes to the above, which medications cause reactions and what is the reaction?

	Name	Reaction	When?
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____

Please list below the name and dose of all medications you are taking and state how often and for what reason you take each one. If you take more than 6 please continue in the blank section at the end of page 5. **Please include frequent over-the-counter medications and alternative medications or herbal remedies.**

	Name	Dose	Times of Day	Reason
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____
C.	_____	_____	_____	_____
D.	_____	_____	_____	_____
E.	_____	_____	_____	_____
F.	_____	_____	_____	_____
G.	_____	_____	_____	_____
H.	_____	_____	_____	_____
I.	_____	_____	_____	_____

Medical and Surgical History (Fill this out only if we do not have your history already.)

Please list or circle your current medical problems, such as high blood pressure, heart disease, stroke, lung disease, etc. and surgeries over last 10 years. If you need more than 9 lines please continue in the blank section at the end of page 5 or on the back.

High Blood Pressure | Acid Reflux | Head Injury (with unconsciousness or side effects) | Stroke | Heart Attack | Diabetes

Ever had a seizure | Thyroid Gland Problems | Anemia | Kidney Problems

A. _____

B. _____ _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

Psychological History

Do you feel depressed? Never | Rarely | Occasionally | Frequently | Always

Do you feel depressed now? Yes | No

Have you had a personality change? Yes | No

If yes to the above, please describe _____

_____

Have you ever seen a psychiatrist or any other type of counselor? Yes | No

If yes to the above, are you currently seeing a psychiatrist or a counselor? Yes | No

Please circle any of the following symptoms that you have had over the last two weeks.

Felt sad frequently? | Felt guilty about anything? | Have a low energy level? | Difficulty with concentration? | Felt like doing little?

Lost interest in things (hobbies / activities) you used to do for fun? | Had appetite changes (increased or decreased)? | Felt like killing yourself?

Do you consider yourself to be under a great deal of stress on most days? Yes | No

If yes to above, what is this from? _____

Social Habits

Have you ever smoked cigarettes? Yes | No

Do you currently smoke cigarettes? Yes | No

If you previously smoked, when did you quit? _____

If you are a smoker or previously smoked, estimate how many packs per day? _____ How many total years of cigarette smoking? _____

Have you ever smoked cigars? Yes | No Currently? Yes | No

Have you ever chewed tobacco? Yes | No Currently? Yes | No

Have you ever smoked a pipe? Yes | No Currently? Yes | No

Please fill the chart below with the number of cups per day and at what time(s) of the day you drink them.

Caffeinated Coffee _____ cups per day @ _____ : _____ AM | PM

Decaffeinated Coffee _____ cups per day @ _____ : _____ AM | PM

Caffeinated Soft Drinks _____ cups per day @ _____ : _____ AM | PM

Do you currently smoke marijuana or take any other mood altering illicit drugs? Yes | No

If yes to the above, what and how often? _____

Do you currently drink alcohol? Yes | No

If yes to the above, on the average, how many alcoholic drinks do you take on weekdays (*working days*)? **(1 glass of wine, 1 shot of liquor, or 1 beer = 1 drink)**

_____ per day of _____ (*type of liquor*)

On the average, how many alcoholic drinks do you take on the weekend days (*non-working days*)? **(1 glass of wine, 1 shot of liquor, or 1 beer = 1 drink)**

_____ per day of _____ (*type of liquor*)

Have you ever felt annoyed by others when they have expressed concerns regarding your drinking? Yes | No

Have you ever felt guilty about your drinking? Yes | No

Have you ever had the need to drink in the morning as an eye-opener? Yes | No

Do you ever have a drink just before going to sleep? Yes | No

Have you ever felt the need to cut down on your alcohol? Yes | No

Current Occupation: _____

Involves significant amounts of driving? Yes | No Do you work with dangerous machinery? Yes | No

What time do you start work on average? _____ : _____ AM | PM

What time do you end your work day? _____ : _____ AM | PM

Do your work hours vary from day to day? Yes | No

Family History

Do members of your immediate family (e.g., father | mother | brother | sister | children) snore? Yes | No (If so, please circle who.)

Have members of your immediate family (e.g., father, mother, brother, sister, children) been diagnosed with sleep apnea? Yes | No

Do members of your immediate family have excessive daytime sleepiness? Yes | No

If yes to above, explain _____

Do other members of your immediate family have any other problems with sleep? Yes | No

If yes to above, explain _____

Do you have any other comments about your sleep? _____

_____

Thank you for taking the time to complete this questionnaire!