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www.PMSleepCenters.com

PATIENT SLEEP HISTORY QUESTIONNAIRE

Today's Date: _____

SECTION I: PATIENT INFORMATION

Patient Name: _____ DOB: _____ Height (inches): _____

Age: _____ Gender: _____ Neck Circumference (inches): _____ Weight (pounds): _____

Referring Physician: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SECTION II: MAJOR SLEEP-RELATED COMPLAINT

☐ Excessive sleepiness ☐ Awaken with headaches ☐ Waking too early ☐ Snoring

☐ Choking sensation during sleep ☐ Difficulty falling asleep ☐ Stop breathing during sleep ☐ Sleep walking

☐ Frequent sleep disruptions ☐ Difficulty staying asleep ☐ Other (please explain):

1. How long have you had your symptom(s)? _____ Years _____ Months

2. How did your symptom(s) begin? ☐ Suddenly ☐ Gradually ☐ Other: _____

SECTION III a: DAYTIME SYMPTOMS

3 Please answer the following questions with the understanding that FATIGUE means feeling "worn out" and SLEEPINESS means "a need to sleep" or actually dozing off unintentionally.

3a. What word best describes your level of daytime FATIGUE in the last month?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

3b. What word best describes your level of daytime SLEEPINESS in the last month?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

4. How long has daytime sleepiness been a problem for you? (Check NA if you have no sleepiness.) _____ **years** ☐ NA

5. Do you feel rested when you wake up from your usual sleep period? ☐ Never ☐ Sometimes ☐ Most times

6. Do you take naps during the day? ☐ Never ☐ Sometimes ☐ Most times

7 Do you feel refreshed after brief (less than 1 hour) naps? ☐ Never ☐ Sometimes ☐ Most times

8. Do you sleep longer on weekends or holidays than on weekdays? ☐ Never ☐ Sometimes ☐ Most times

9. Do you use medicine to help you stay awake? ☐ Never ☐ Sometimes ☐ Most times

10. During the past month, how much has sleepiness interfered with your normal work performance? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

11. During the past month, how much has sleepiness interfered with normal social activities with family, friends and other groups? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

12. Have you had recent accidents or near accidents because of sleepiness? (i.e., car, work, home) ☐ Yes ☐ No

13. Have you had sudden physical weakness of arms, legs or face when angry, laughing, crying or during other heightened emotional situations? ☐ Yes ☐ No

14. When you fall asleep or just before you awaken do you have bizarre dreams? ☐ Yes ☐ No

15 When you fall asleep or just before you awaken do feel as if you are paralyzed? ☐ Yes ☐ No

16. Have you ever been told that you have Narcolepsy? If yes, when and by whom? ☐ Yes ☐ No

SECTION III b EPWORTH SLEEPINESS SCALE

Please read the questions below and rate the chances that you would doze off or fall asleep (in contrast to just feeling tired) during different routine situations. These situations should refer to your usual way of life in recent times. Please use the scale described below (0 through 3) to rate each question.

0 = Would **never** doze or sleep 1 = **Slight** likelihood of dozing or sleeping	2 = **Moderate** likelihood of dozing or sleeping 3 = **High** likelihood of dozing or sleeping

Situation	**Rating**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a 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 down and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in traffic	
17. Add all of the ratings together for **Total Score** →	

SECTION IV: SLEEP HABITS

18. Workday usual bedtime: _____ ☐ a.m. ☐ p.m.

19. Workday usual wake time: _____ ☐ a.m. ☐ p.m.

20. Non-workday usual bedtime: _____ ☐ a.m. ☐ p.m.

21. Non-workday usual wake time: _____ ☐ a.m. ☐ p.m.

22. How many hours of sleep do you feel that you achieve on average during this period? _____ Hours

23. How many hours of sleep do you feel you need to feel alert during your waking period? _____ Hours

24. How long does it usually take you to fall asleep? _____ Hours _____ Minutes

25. How often are you likely to awaken during the night? ☐ Rarely ☐ 3 times or less ☐ Frequently

26. Do you currently have a bed partner or sleep observer? (If yes, ask them to complete Section IX.) ☐ Yes ☐ No

27. Have you been told that you snore loudly? (If Yes, how many years has snoring been noted?) ☐ Yes ☐ No

_____ Years

28. Have you been told that you stop breathing during sleep? (If Yes, for how many years?) ☐ Yes ☐ No

_____ Years

29. Have you been told that your arms and legs jerk during sleep? ☐ Yes ☐ No

30. Do you often awaken at night with a sensation in your lower legs that goes away when you walk around? ☐ Yes ☐ No

31. If yes, to #30 above, do the sensations in your lower leg become worse when you get into bed, making it difficult to fall asleep? ☐ Yes ☐ No

SECTION V: RELATED MEDICAL INFORMATION

32. Do you or have you ever suffered from any of the following? (Check all that apply.)

☐ High blood pressure ☐ Angina / Heart attack ☐ Diabetes

☐ Chronic nasal / sinus problems ☐ Heart failure (CHF) ☐ Thyroid disease

☐ Chronic lung disease (COPD, Emphysema) ☐ Irregular heart beat ☐ Treatment for depression

☐ Asthma ☐ Pacemaker / Defibrillator ☐ Restless Leg Syndrome

☐ Other (please explain): _____

33. List any major medical problems or illnesses you have had in the past that are not listed.

_____

_____

SECTION VI: MEDICATIONS

34 List all **MEDICATIONS** that you are currently taking. Be sure to list prescription and non-prescription medications, including sleep agents.

Medication Name	***Dosage Per Day***	***For How Long***	***Purpose***
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	
		_____ Yrs _____ Mos	

35. List all **MEDICATION ALLERGIES** you may have. _____

_____

36. Do you have any allergies or sensitivities to any tape or bandage? ☐ Yes ☐ No

37. Do you have any allergies or sensitivities to latex? ☐ Yes ☐ No

SECTION VII: PREVIOUS SLEEP APNEA DIAGNOSIS & TREATMENT

38. Have you ever been diagnosed with sleep apnea? If Yes, when? _____ ☐ Yes ☐ No

If Yes to above, are you currently being treated with CPAP / Bi-level therapy? ☐ Yes ☐ No

Do you feel any difference when using CPAP / Bi-level during sleep? ☐ Yes ☐ No

If currently using positive airway pressure therapy, please indicate the prescribed pressure. _____ cm of water

39. Have you had any surgical treatment(s) for sleep apnea? ☐ Yes ☐ No

40. Have your tonsils been removed? If yes, when? _____ ☐ Yes ☐ No

41. Do you use a dental appliance for sleep apnea or teeth grinding? ☐ Yes ☐ No

SECTION VIII: SOCIAL HABITS & FAMILY HISTORY

42. Do you drink alcoholic beverages? If yes, please indicate type, quantity and frequency below. ☐ Yes ☐ No
If Yes, What type? _____ Number of glasses/cans/bottles? _____ per ☐ day ☐ week ☐ month

43. Do you drink caffeinated beverages? If yes, please indicate type, quantity and frequency below. ☐ Yes ☐ No
If Yes, What Type? _____ How many glasses/cans/cups? _____ per ☐ day ☐ week ☐ month

44. Have you gained any weight over the last year?. ☐ Yes ☐ No
If Yes, how much? _____ pounds

45. Do other family members have similar sleep problems? ☐ Yes ☐ No

46. What is your occupation? _____

47. What are your usual working hours? _____

48. Please use the following space to elaborate on other related information about your medical or sleep complaints.

SECTION IX: OBSERVATIONS OF OTHERS

49. If you have had opportunities to observe this patient's sleep please check any behaviors that apply and how long they have occurred.

☐ Snore or Snort	___ Years	___Months	☐ Stop breathing/Gasp for air	___ Years	___Months
☐ Leg/arm/body jerks	___ Years	___Months	☐ Violent Behavior/Acting Out Dreams	___ Years	___Months
☐ Grind teeth	___ Years	___Months	☐ Screaming/walking in sleep	___ Years	___Months

50. Use the space provided for additional comments. _____