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Phone 763-519-0634 FAX 763-519-0636

# Sleep History Questionnaire

B/P \_\_\_\_\_/\_\_\_\_\_  
Pulse: \_\_\_\_\_  
Neck Circum \_\_\_\_\_  
Wgt: \_\_\_\_\_  
Pulse Ox \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

If no Referring Physician, how did you hear about us?



Current Medications

Dosage and Frequency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use supplemental oxygen? YES NO

Amount: \_\_\_\_\_ l/min

Medication Allergies: \_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: at present \_\_\_\_\_ 1 year ago \_\_\_\_\_ high school \_\_\_\_\_

For Doctor's Use:

# Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to think how you would react. Use the following scale to choose the **most appropriate number rating** for each situation.

- 0 = would NEVER doze
- 1 = SLIGHT chance of dozing
- 2 = MODERATE chance of dozing
- 3 = HIGH chance of dozing

- 1. Sitting and reading \_\_\_\_\_
  - 2. Watching TV \_\_\_\_\_
  - 3. Sitting, inactive, in a public place \_\_\_\_\_
  - 4. As a passenger in a car for an hour without a break \_\_\_\_\_
  - 5. Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_
  - 6. Sitting and talking to someone \_\_\_\_\_
  - 7. Sitting quietly after lunch \_\_\_\_\_
  - 8. In a car, while stopped for a few minutes in traffic \_\_\_\_\_
- Total \_\_\_\_\_

- 1. Do you suffer from nasal allergies? Yes No
- 2. Have you had corrective nasal surgery? Yes No
- 3. Do you take any medications that cause you to suffer from dry mouth? Yes No
- 4. Do you sleep in a cool room? (less than 65 degrees) Yes No
- 5. Do you sleep with the windows open year round? Yes No
- 6. Do you feel like you have chronic nasal congestion issues? Yes No
- 7. Are you over the age of 60? Yes No

## Today's Chief Complaint - answer all that apply

- |                                      | Duration             |             |
|--------------------------------------|----------------------|-------------|
| Excessively tired throughout the day | _____years           | _____months |
| Gasping for air during the night     | _____years           | _____months |
| Snoring                              | _____years           | _____months |
| Can't fall asleep at night           | _____years           | _____months |
| Can't stay asleep at night           | _____years           | _____months |
| Unusual behaviors during sleep       | Please explain _____ |             |
| Other                                | _____                |             |

## Sleep Patterns/Environment

**Weekdays**

**Weekends**

Typical bedtime \_\_\_\_\_

Amount of time to fall asleep \_\_\_\_\_

Time up in the morning \_\_\_\_\_

Average # of hours slept \_\_\_\_\_

Average # of awakenings per night \_\_\_\_\_

Number of bathroom trips \_\_\_\_\_

Number of naps \_\_\_\_\_

Sleep disturbances - circle all that apply

Pain            Anxiety            Spouse            Snoring            Pets            Children

Breathing      Coughing      Worrying      Other: \_\_\_\_\_

Do you have aching or restlessness in your legs at night with an urge to move them? YES NO

Number of nights per week you are using alcohol before bed: \_\_\_\_\_

Do you currently use a sleep aid? YES NO name: \_\_\_\_\_

Do you awake in the morning feeling refreshed? YES NO

Any history of accidents (work or car) due to sleepiness? YES NO

Please describe if YES: \_\_\_\_\_

## Past Sleep Evaluation and Treatment - answer all that apply

***If this is your first evaluation skip to next section***

My last sleep evaluation was:  
\_\_\_\_\_ less than 6 months ago      \_\_\_\_\_ less than 1 year ago      \_\_\_\_\_ years ago

Where: \_\_\_\_\_

It included:                      Overnight Sleep Study                      Daytime Naps

I was diagnosed with: \_\_\_\_\_

I use a CPAP or Bi-Level Machine                      YES                      NO  
if yes, what is your pressure setting? \_\_\_\_\_ cm/H<sub>2</sub>O

I have had surgery to treat a sleep disorder                      YES                      NO  
if yes, what type of surgery was performed? \_\_\_\_\_

I have been prescribed medication to treat a sleep disorder                      YES                      NO  
list medication: \_\_\_\_\_

**Past Medical History - please circle all that apply**

High Blood Pressure      Stroke      Diabetes      Depression      Anxiety  
Asthma/Emphysema      Reflux      Seizures      Heart Disease      Cancer  
Parkinson’s Disease      Fibromyalgia      Lung conditions      Thyroid Conditions  
Head Injury      Hearing Impairment

List any other medical problems that may disrupt your sleep:

\_\_\_\_\_

List any surgeries and the year performed:

\_\_\_\_\_

**Social History**

Marriage Status:      Married      Single      Divorced      Widowed

Sleep Arrangements:      Sleep alone      Share bed      Separate Beds

Occupation: \_\_\_\_\_      Employed      Unemployed      Retired      Student

Do you smoke?    YES    NO    Are you a former smoker?    YES    NO

Cigarettes/Cigars/Tobacco \_\_\_\_\_ packs/day      for \_\_\_\_\_ years

Year quit \_\_\_\_\_      Packs/day \_\_\_\_\_ for \_\_\_\_\_ years

Do you drink alcohol?    YES    NO

Amount: \_\_\_\_\_      Type of alcohol: \_\_\_\_\_

Frequency: Daily      Weekends      Occasionally

Caffeine?    YES    NO      Amount: \_\_\_\_\_ cups    \_\_\_\_\_ cans    per day

**Family History - please circle all that apply**

**Mother**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Father**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Sister(s)**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Brother(s)**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

Other \_\_\_\_\_

1. I have trouble falling asleep.	Never	Sometimes	Always
2. I have trouble staying asleep.	Never	Sometimes	Always
3. I read or watch TV in bed before falling asleep.	Never	Sometimes	Always
4. I often wake up during the night.	Never	Sometimes	Always
5. At bedtime, thoughts race through my mind.	Never	Sometimes	Always
6. I smoke less than 2 hours before going to bed.	Never	Sometimes	Always
7. I eat a snack at bedtime.	Never	Sometimes	Always
8. If I wake up at night I eat a snack.	Never	Sometimes	Always
9. I have nightmares.	Never	Sometimes	Always
10. I sweat a lot during the night.	Never	Sometimes	Always
11. I kick my legs and/or arms during the night.	Never	Sometimes	Always
12. I walk in my sleep.	Never	Sometimes	Always
13. I talk in my sleep.	Never	Sometimes	Always
14. I grind my teeth while I sleep.	Never	Sometimes	Always
15. I wake up at night choking or gasping for air.	Never	Sometimes	Always
16. I wake my self up with my snoring.	Never	Sometimes	Always
17. I have been told I snore while lying on my back.	Never	Sometimes	Always
18. I feel my heart pounding at night.	Never	Sometimes	Always
19. At bedtime I feel sad or depressed.	Never	Sometimes	Always
20. I feel unable to move (paralyzed) after a nap.	Never	Sometimes	Always
21. I have dream like images when I wake up even though I know I am not asleep.	Never	Sometimes	Always
22. I have experienced sudden muscle weakness in response to emotions such as laughter or surprise.	Never	Sometimes	Always
23. I take a nap(s) on a regular basis.	Never	Sometimes	Always
24. I have fallen asleep while driving.	Never	Sometimes	Always
25. I get "stuffed up" while sleeping.	Never	Sometimes	Always
26. My breathing is worse when I sleep on my back.	Never	Sometimes	Always
27. I get morning headaches.	Never	Sometimes	Always
28. I wake up with a dry mouth.	Never	Sometimes	Always
29. Pain wakes me up at night.	Never	Sometimes	Always
30. I wet the bed.	Never	Sometimes	Always
31. I wake up due to heartburn, reflux, a sour stomach, or burping.	Never	Sometimes	Always