SLEEP HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ MRN: _____

1. Do you snore? ☐ Yes ☐ No

(If yes, answer a – h.)

a. Is your snoring loud? ☐ Yes ☐ No

b. Is it worsening? ☐ Yes ☐ No

c. In which position do you snore?

☐ Back only ☐ All positions

d. Is it worse on your back? ☐ Yes ☐ No

e. Do you snore if you fall asleep in a chair?

☐ Yes ☐ No

f. Does your snoring disturb others?

☐ Yes ☐ No Who?

g. Has anyone ever noticed if you stop breathing while you sleep?

☐ Yes ☐ No

h. Do you gasp or choke while you sleep?

☐ Yes ☐ No

2. Check if you suffer from the following:

☐ Dry mouth ☐ Headaches

3. Do you feel sleepy in the daytime?

☐ Yes ☐ No

If yes, answer the following:

a. How many days per week? _____

b. When did it start? _____

c. Is it worsening? _____

4. How likely are you to fall asleep?

Please use the following scale:

0 - Would never doze

1 - Slight chance of dozing

2 - Moderate chance of dozing

3 - High chance of dozing

_____ Sitting and reading

_____ Watching television

_____ Sitting inactive in a public place

_____ While a passenger in a car without a break

_____ Laying down to rest in the afternoon

_____ Sitting and talking to someone

_____ Sitting quietly after a lunch without alcohol

_____ In a car while stopped in traffic for a few minutes

a. Have you ever had a close call or accident while driving because of sleepiness?

☐ Yes ☐ No

b. Do you suffer from memory problems?

☐ Yes ☐ No

c. Do you take daytime naps? ☐ Yes ☐ No

How many per week? ☐ Yes ☐ No

How long do they last? ☐ Yes ☐ No

Are the naps refreshing? ☐ Yes ☐ No

d. Rate the severity of your sleepiness on a scale from 1 to 10.

1 = no sleepiness / 10 = very severe sleepiness

SLEEP HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ MRN: _____

5. Do you ever experience restlessness or discomfort in your legs?

☐ Yes ☐ No

When? _____

What do you do to relieve it? _____

How often does it occur? _____

Does it interfere with sleep? ☐ Yes ☐ No

Do you move or kick your legs while sleeping?

☐ Yes ☐ No

6. Have you ever felt a sudden loss of strength (arms or legs) in response to some emotional experience?

☐ Yes ☐ No

7. Have you ever felt paralyzed when you first wake up or when you are falling asleep?

☐ Yes ☐ No

8. Do you ever dream while you are falling asleep or during naps?

☐ Yes ☐ No

9. Do you ever walk or talk in your sleep?

☐ Yes ☐ No

10. Do you accidentally urinate while you are sleeping?

☐ Yes ☐ No

11. Do you have nightmares? ☐ Yes ☐ No

12. Tell us about your sleep schedule:

a. What is your bedtime? _____

b. What time do you get up for the day? _____

c. How long does it take you to fall asleep? _____

d. Do you wake up in the middle of the night?

☐ Yes ☐ No

How many time per night? _____

Do you fall asleep again easily?

☐ Yes ☐ No

13. Tell us about your sleep schedule:

a. What are your work hours? _____

b. If you don't work, how do you occupy your day?

_____

_____

c. What do you do in the evenings?

_____

_____

14. Do you have any family members with sleep apnea or other sleeping disorder?

☐ Yes ☐ No

If so, list whom and what type of disorder.

_____

_____

_____

Patient Signature _____ Date _____

Reviewer Signature _____ Time _____ Date _____