Patient Initials:_____Provider signature:_____Date:_____

Health and Sleep History Questionnaire

Name_____

Age_____ Race/Ethnicity_____Date_____

Name of Primary Physician: _____

Name of Referring Physician (*if not your primary physician*): _____

Briefly describe the problem(s) you are experiencing with your sleep or the reason you were referred to our sleep center.

_____
_____
_____

When did you first notice your sleep problem? What may have contributed to the onset of your difficulty sleeping (i.e. birth of a child, death of a loved one, traumatic event)? _____
_____
_____

What do you feel are the major contributors to your sleep problem at this time? _____
_____
_____

What medications and other treatments have you tried for your sleep problem to date?_____
_____
_____

What medication(s) are you currently taking for sleep? And how many times per week?_____
_____

How long (on average) does it take you to get to sleep? _____

How many times do you wake up in an average night? _____
How long on average do you remain awake during these awakenings (in total)? _____

How much sleep do you get in total in an average night? _____hours/night

How much sleep do you feel you need each night to feel well rested and able to function? _____hours/night

Does a poor night's sleep make you:

	Yes	No
Depressed	☐	☐
Anxious	☐	☐
Irritable	☐	☐
Fatigued	☐	☐

Does a poor night's sleep negatively affect your:

	Yes	No
Ability to concentrate	☐	☐
Memory	☐	☐
Ability to work	☐	☐
Mood	☐	☐

Other (please describe):_____

Patient Initials:_____Provider signature:_____Date:_____

Psychosocial History:

In what city/county do you live?_____

Who do you live with?_____

Status: ☐ Never Married ☐ Currently Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Is your current relationship satisfactory(circle)? **Yes or No or Not applicable**
If **No**, please explain:_____
_____

How many total years of education have you completed?_____

What college degree(s)/certificates have you earned? _____
_____

Where do you work and what is your profession? _____
_____

How long have you worked there? _____Years _____Months

Are you satisfied with your job? **Yes or No** If **No**, please explain_____
_____

Do you have children? **Yes or No** If yes, how many?_____

Are you experiencing any problems/conflicts related to your children? **Yes or No**
If yes, please explain_____
_____

Are you experiencing any family related conflicts or problems? **Yes or No** If yes, please explain:_____
_____

How is your social life (circle)? **Excellent** **Good** **Fair** **Limited** **Poor**

How is your activity level (circle)? **Excellent** **Good** **Fair** **Limited** **Poor**

Have you ever smoked? YES ☐ NO ☐ How Long? ___Years How Much? ___Packs/day When quit?_____

Do you drink alcohol of any kind? YES ☐ NO ☐ How many times per week?_____ How many drinks? _____

Do you drink caffeinated beverages? YES ☐ NO ☐ How many times per week?_____ How many drinks? _____

Have you ever used marijuana, cocaine, or other illicit drugs? YES ☐ NO ☐
If **YES**, which drug and how often? _____

Patient Initials:_____ Provider signature:_____ Date:_____

Medical History

Surgery	Surgeries: YES	NO	When?
Tonsillectomy	☐	☐	_____
Hernia	☐	☐	_____
Cardiac Bypass	☐	☐	_____
Hysterectomy	☐	☐	_____
Appendectomy	☐	☐	_____
Nasal Surgery	☐	☐	_____

Other:_____

_____

_____

_____

_____

Have you ever experienced a head injury?

☐ Yes ☐ No

If yes, when?_____

Condition	YES	NO	When Diagnosed?
Allergies/Asthma	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Cardiovascular Disease	☐	☐	_____
Diabetes	☐	☐	_____
Digestive Problems	☐	☐	_____
Hypertension	☐	☐	_____
Kidney Problems	☐	☐	_____
Liver Problems	☐	☐	_____
Respiratory Problems	☐	☐	_____
Thyroid Disorder	☐	☐	_____
Seizure Disorder	☐	☐	_____
Pain Condition**	☐	☐	_____

** Rate the severity of your pain, on a scale from 0-10, with 10 indicating the most severe pain you can imagine. _____.

Other:_____

_____

_____

Prescription Medications	Dosage	Taken For	How Long?
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			

Over the counter medications _____

_____

_____

Patient Initials:_____Provider signature:_____Date:_____

Psychiatric History

Are you currently being treated for a psychiatric disorder? YES ☐ NO ☐

If **YES**, who are your current providers and what is the focus of treatment?_____

_____

_____

_____

Have you ever been diagnosed or treated for a psychiatric disorder? YES ☐ NO ☐

If **YES**, when and what was your diagnosis and treatment outcome _____

_____

_____

Do you have a family history of…(please circle all that apply) **Depression Anxiety Bi-Polar D/O Psychosis Other:**_____

How would you rate your current level of sadness or depression on a scale from 0-10, with 0 indicating no depression to 10 indicating very severe depression? _____

To what would you attribute this sadness/depression or what do you feel is causing this level of depression?_____

_____

How would you rate your current level of stress or anxiety on a scale from 0-10, with 0 indicating no anxiety to 10 indicating very severe anxiety? _____

To what would you attribute this stress/anxiety, or what do you feel is causing this level of anxiety ?_____

_____

	YES	NO
Have you ever been hospitalized for psychiatric reasons?	☐	☐

If Yes, where and for how long?_____

_____

Are you currently prescribed psychiatric medications (i.e. antidepressants, anti-anxiety, mood stabilizers etc.)?	☐	☐
Have you ever been physically, emotionally, or sexually abused?	☐	☐
Have you ever felt so bad that you wanted to die or considered taking your own life?	☐	☐

Patient Initials:_____ Provider signature:_____ Date:_____

Sleep Symptoms:

	YES	NO
Has anyone told you that you snore loudly?	☐	☐
Has your family told you that you quit breathing at night?	☐	☐
Have you ever awakened gasping for breath?	☐	☐
Have you ever awakened at night with a sour taste in your mouth, or a burning sensation in your chest?	☐	☐
Do you have morning headaches?	☐	☐
Are you sleepy even when you increase your sleep time?	☐	☐

	YES	NO
Do you have trouble getting to sleep at night?	☐	☐
Do you have trouble staying asleep at night?	☐	☐
Do you have frequent awakenings and/or restless sleep?	☐	☐

	YES	NO
Do you frequently kick and jerk your legs at night while trying to fall asleep?	☐	☐
Do you have discomfort in your legs while trying to fall asleep?	☐	☐
If YES to previous question, does moving your legs give you relief of discomfort?	☐	☐
Do you have tingling or discomfort in your legs during the day?	☐	☐
Do you have discomfort in your legs when sitting for long periods?	☐	☐

	YES	NO
Do you have sudden episodes of sleep during the day?	☐	☐
Have you ever experienced periods in which you feel paralyzed while going to sleep, or waking up?	☐	☐
Have you ever had visual hallucinations or dream-like mental images when falling to sleep?	☐	☐
Have you ever experienced sudden physical weakness during strong emotions? (such as your mouth dropping open or legs going limp, during laughter or anger)	☐	☐
Were you excessively sleepy as a teenager or young adult?	☐	☐

	YES	NO
Do you sleep walk?	☐	☐
Do you talk in your sleep?	☐	☐
Do you have frequent nightmares?	☐	☐
Do you ever wake up screaming at night?	☐	☐
Do you eat in the middle of the night?	☐	☐
Do you physically act out your dreams at night?	☐	☐

	YES	NO
Do you grind your teeth in your sleep?	☐	☐
Have you or your dentist noticed your teeth being worn down?	☐	☐
Have you noticed that your teeth hurt?	☐	☐
Do you experience pain in your jaw muscles?	☐	☐
Has anyone told you that you make sounds with your teeth or jaw during sleep?	☐	☐

Patient Initials:_____ Provider signature:_____ Date:_____

	YES	NO
Do you have rotating or night shift work?	☐	☐
Have you ever worked shift work or had an on-call schedule?	☐	☐
Do you have difficulty getting to sleep at your desired time?	☐	☐
Do you wake up in the morning prior to your desired time?	☐	☐
Do you find that your present sleep schedule is inconvenient, inappropriate, or unsatisfactory?	☐	☐

Sleep Schedule

	Weekday	Weekend
Time you go to bed	_____	_____
Time you get up	_____	_____
Average amount of sleep per night	_____	_____

Name _____

Sleep Medicine Specialists

Sleep Hygiene Practice Scale

How often do you do the following activities during an average week?

Read in bed..... _____ times a week
Watch TV in bed..... _____ times a week
Eat in bed..... _____ times a week
Work in bed..... _____ times a week
Argue in bed..... _____ times a week
Worry in bed..... _____ times a week
Use sleeping medication (prescription or over the counter)..... _____ times a week

Drink beverages containing caffeine within 4 hours of bedtime. _____ times a week
Use alcohol to help you sleep..... _____ times a week
Smoke more than a pack of cigarettes..... _____ times a week
Go to bed hungry or thirsty..... _____ times a week
Drink more than 3 ounces of alcohol (e.g. 3 mixed drinks, beers, 3 glasses of wine) before bedtime..... _____ times a week
Take medications / drugs with caffeine within 4 hours of Bedtime..... _____ times a week
Exercise strenuously within 2 hours of bedtime..... _____ times a week
Exercise in the afternoon or early evening ..... _____ times a week
Sleep approximately the same length of time each night..... _____ times a week
Set aside time to relax before bedtime..... _____ times a week

Have your sleep disturbed by light..... _____ times a week
Have your sleep disturbed by noise..... _____ times a week
Have your sleep disturbed by a bed partner..... _____ times a week
Have a comfortable nighttime temperature in your bed or bedroom..... _____ times a week

Name:_____

Sleep Medicine Specialists

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