SLEEP HISTORY
CONFIDENTIAL QUESTIONNAIRE

SleepCare

APPOINTMENT DATE: ___________________

Please bring questionnaire with you on the night of your appointment.

NAME: ____ DOB: ____/____/_______
(First) (Middle) (Last)

AGE: ________________

ADDRESS: ____
(Street) (City) (State) (Zip)

PHONE: (Home) ______________________________ (Work) _____________________________

(Cell) ______________________________

HEIGHT: _____ ft _____ in. CURRENT WEIGHT: ____________ lbs.

WEIGHT 1 YEAR AGO _________ lbs. WEIGHT 5 YEARS AGO _________ lbs.

MALES: NECK COLLAR SIZE __________________ in.

IN CASE OF EMERGENCY CONTACT: ____
(Name) (Phone) (Relationship)

PRIMARY CARE
PHYSICIAN NAME:____ PHONE: ______________________

ADDRESS:____

REFERRING
PHYSICIAN NAME:____ PHONE: ______________________

ADDRESS:____

REFERRING
PHYSICIAN NAME:____ PHONE: ______________________

ADDRESS:____

Note: Sleep study report(s) will be forwarded to above physician(s).

How did you hear about our sleep laboratory?
( ) Physician ( ) Journal/Magazine ( ) Sleep Society ( ) Relative ( ) Friend
( ) TV ( ) Radio ( ) Newspaper ( ) Seminar/Presentation ( ) Online Search
( ) Website – www.chsbuffalo.org

The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. It is important for you to be as accurate as possible in answering the following questions. This information will be held in the strictest confidence

We encourage you to have your spouse, or other household member, help to complete this questionnaire. If this questionnaire is completed by, or with the assistance of, another person please indicate:

Name:____ Relationship:_______________________________

1. Describe your sleep problem(s) in your own words.

2. How often does this problem occur:
   ( ) Almost every night
   ( ) Several times a week
   ( ) A few times a month
   ( ) Very infrequently

3. How long has this problem bothered you?
   ( ) Longer than 2 years
   ( ) 1 to 2 years
   ( ) Several months
   ( ) Within the last 3 months
   ( ) Within the last month

4. On the scale below, please estimate the severity of your problem(s)

_______	_______	_______	_______	_______
Mildly Upsetting	Moderately Severe	Very Severe	Extremely Severe	Totally Incapacitating

5. How strongly do you want to resolve your problem:

_______	_______	_______	_______
Very Much	Much	Moderately	Could do without it

6. Do you have any of the following sleep problems? (Check all that apply)
   ( ) Difficulty falling asleep
   ( ) Frequent awakenings during the night
   ( ) Wake up too early in the morning
   ( ) Difficulty awakening
   ( ) Excessive daytime sleepiness

7. Do any other members of your family have sleep problems?
   ( ) No
   ( ) Yes
   If yes, please explain: ____

8. Are you currently on oxygen, CPAP or BiPAP at home?
   ( ) No
   ( ) Yes
   If yes, what company is your home care provider? ____

9. Have you had an overnight oximetry test at home?
   ( ) No
   ( ) Yes
   If yes, what company did the test? ____

10. Have you had a sleep study done in a sleep lab in the past?
    ( ) No
    ( ) Yes
    If yes, specify where & when testing was done: ____

Please answer the sleep complaints that either you or someone else has noted in the past year:

	Never or Nearly never	Rarely (1-2 times Per month)	Sometimes (1-2 times Per week)	Frequently (3 – 4 times Per week)	Constantly (Nearly Everyday)
Snore	________	________	________	________	________
Snore loudly enough that others complain	________	________	________	________	________
Observed me stopping breathing while asleep	________	________	________	________	________
I suddenly wake at night Gasping/choking for breath	________	________	________	________	________
I can hear myself snoring	________	________	________	________	________
I have difficulty breathing through my nose	________	________	________	________	________
I wake up with a dry mouth	________	________	________	________	________
I wake in the morning with a headache	________	________	________	________	________
I sweat excessively at night	________	________	________	________	________
I have no energy in the daytime	________	________	________	________	________
I am tired all the time	________	________	________	________	________
I can't concentrate at work/school	________	________	________	________	________
I take naps during the day	________	________	________	________	________
I have had work accidents because I'm tired	________	________	________	________	________
I fall asleep while driving	________	________	________	________	________
I have to pull off the road to nap	________	________	________	________	________
I wake up at night and can't go back to sleep	________	________	________	________	________
My mind won't stop and let me sleep	________	________	________	________	________
I can't relax	________	________	________	________	________
I worry about things	________	________	________	________	________
I have nightmares	________	________	________	________	________
I remember my dreams	________	________	________	________	________
I eat after 8 p.m.	________	________	________	________	________

	Never or Nearly never	Rarely (1-2 times Per month)	Sometimes (1-2 times Per week)	Frequently (3 – 4 times Per week)	Constantly (Nearly Everyday)
I drink alcohol in the evening	________	________	________	________	________
I drink coffee and/or caffeine soft drinks after 3 p.m.	________	________	________	________	________
I have indigestion if I eat late	________	________	________	________	________
I wake up choking with food or acid in my mouth	________	________	________	________	________
I cough at night	________	________	________	________	________
I wake up with my heart pounding or skipping beats	________	________	________	________	________
I have chest pain at night	________	________	________	________	________
I fall asleep involuntarily	________	________	________	________	________
I fall asleep at work/school	________	________	________	________	________
I fall sleep during movies or at parties	________	________	________	________	________
I have sudden, brief loss of strength in Muscles triggered by emotions (laughter, anger, surprise)	________	________	________	________	________
I feel like I am unable to move when falling asleep	________	________	________	________	________
I feel like I am unable to move When waking up	________	________	________	________	________
I have vivid dreams as I fall asleep	________	________	________	________	________
I have vivid dreams as I wake up	________	________	________	________	________
I kick or jump in my sleep	________	________	________	________	________
I feel an unpleasant "creepy, crawly" sensation in my legs when I am sitting or lying still	________	________	________	________	________
The pain and unpleasant feeling in my legs can be temporarily relieved by stretching or moving my legs (leave blank if first part of sentence does not apply)	________	________	________	________	________
My legs cramp at night	________	________	________	________	________
After a full night sleep I still wake up tired	________	________	________	________	________
I grind my teeth during sleep	________	________	________	________	________

	Never or Nearly never	Rarely (1-2 times Per month)	Sometimes (1-2 times Per week)	Frequently (3 – 4 times Per week)	Constantly (Nearly Everyday)
I have morning jaw pain	________	________	________	________	________
I'm bothered by pain during the day	________	________	________	________	________
I'm bothered by pain during the night	________	________	________	________	________
I wake up feeling stiff, sore, or Achy in the morning	________	________	________	________	________
I sleepwalk	________	________	________	________	________
I have sleep terrors	________	________	________	________	________
I have/had episodes of doing things while asleep (such as eating) of which I have no conscious awareness	________	________	________	________	________
I have been known to have violent behavior while asleep, of which I have no conscious awareness	________	________	________	________	________
I was told that I "rock" in my sleep	________	________	________	________	________
I talk in my sleep	________	________	________	________	________

11. How many hours of sleep do you usually get per night? __________________

12. What time do you usually go to bed on **Workdays**? ___________ **Non-Workdays**? ______________

13. How long does it usually take to fall asleep? _______________________

14. How many times do you typically wake up at night?________________

15. If you do awaken during the night (after you first fall asleep) during which part(s) of your sleep does it occur?
( ) Soon after falling asleep ( ) Middle of the night ( ) Early morning

16. What do you usually do when you awaken during the night? ____

17. If you do wake up, on average, how long do you stay awake? _______________________________

18. What time do you usually **awaken** on **Workdays**? ____________ **Non-Workdays**? _____________

19. How long to you usually stay in bed after waking up in the morning? ________________________

20. Does somebody else sleep in the same (check all that apply):
( ) bed ( ) room ( ) house

21. Do you provide assistance to someone during the night (child, invalid, partner, animal)
( ) No ( ) Yes, if so, who? ____

22. Is your sleep often disturbed by:
( ) Heat ( ) Cold ( ) Light ( ) Bed partner ( ) Noise
( ) Not being in your usual bed ( ) Other ___________________________________

23. Do you work:
( ) Evening shift ( ) Night shift ( ) Split shifts
( ) Rotating (variable) shifts? (specify details)________________________
( ) None of the above

24. Do you usually drink coffee or tea within 2 hours before you go to bed:
( ) No ( ) Yes

25. Do you do physical exercise before bedtime?
( ) No ( ) Yes

26. Do you usually watch TV in bed?
( ) No ( ) Yes

27. Do you usually read before falling asleep?
( ) No ( ) Yes

28. Do you feel refreshed after a short (10 – 15 minute) nap?
( ) No ( ) Yes

29. Indicate any problems you have (check all that apply):
( ) High Blood Pressure
( ) Cardiac Disease: details-________________________
( ) Asthma
( ) COPD (Chronic bronchitis/emphysema)
( ) Chronic Cough
( ) Shortness of Breath- (check all that apply): ( )At rest ( )On exertion ( )Lying flat
( ) Allergies- specify- ________________________
( ) Seizures
( ) Diabetes
( ) Thyroid Disease
( ) Heartburn/GERD
( ) Depression
( ) Anxiety
( ) Claustrophobia
( ) Sinus problems
( ) Chronic Pain: details- ________________________
( ) Infectious conditions (i.e., shingles)- specify________________________
( ) Surgeries related to ear, nose, throat- details________________________
( ) Other significant medical problems- details ________________________

30. Do you take any medications? (include prescription and non-prescription drug). Attach additional sheet if needed

Name	Amount	How Often	Reason

31. List your usual consumption of the following per day:
Coffee ________________________
Tea ________________________
Cigarettes________________________
Cigars ________________________
Pipe________________________
Alcohol ________________________
Colas ________________________
Chocolate ________________________

Patient Signature ________________________

Thank you for your response.