SANTIAM HOSPITAL embrace HEALTH™

Sleep History Questionnaire

Name: ______________________

Date of Birth: ______________

GENERAL INFORMATION

What is your primary problem with sleep? ______________________________

How long have you had the sleep problem? _________ months _________ years

Have you had a sleeping problem diagnosed in the past? Yes No If yes, what was the problem and treatment(s)?

____

SLEEP PATTERNS

Bedtime on **weekdays/workdays**? _____ am / pm

Wake time on **weekdays/workdays**? _____ am / pm

Hours of sleep on **weekdays/workdays** _____ **hours**

Bedtime on **weekends/days off**? _____ am / pm

Wake time on **weekends/days off**? _____ am / pm

Hours of sleep on **weekends/days off?** _____ **hours**

How often do you take naps? _____ **per day / week**

How long are naps? _____ **minutes / hours**

Are the naps refreshing? Yes / No

Are you refreshed by a nights sleep? **Yes / No**

Do you currently do **shift work**? **Yes / No**

If so is sleeping difficult? Yes/No

Which do you do while in bed? Watch TV Read Listen to music Worry Other: ____________________

What is the **usual number of minutes it takes to fall asleep** at night? ________ minutes

Do you have awakenings during the night? Yes No If **yes**, average # of times per night ________

Why do you awaken? Disturbance by bed partner Pets Children Need to use bathroom Pain Noises My own snoring Shortness of Breath/Gasping/Choking Leg cramps/kicks Other: ____________________

How long are these periods of wakefulness when added together? _________ minutes per night

What do you do during these awakenings at night? Watch TV Read Listen to music Worry Computer Smoke Stay in bed Chores Move to another room Eat Other ____________________

EXCESSIVE SLEEPINESS

How likely are you to **doze off or fall asleep** in the following situations, **in contrast to just feeling tired**? This refers to your usual way of life in recent times. 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 = no chance of dozing 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 (e.g., a theatre or a meeting)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
In a car, while stopped for a few minutes in traffic or at a stop light	________

How long have you had excessive sleepiness in the daytime? ______ months/years (circle one) N/A

Have you had an accident or near-miss accident because of **sleepy driving**? **Yes / No**

Have you ever felt sudden **muscle weakness** when you laughed, got angry, or were surprised? **Yes / No**

Have you ever been **unable to move your body** just as you were falling asleep or waking up? **Yes / No**

Do you have difficulty **distinguishing your dreams from reality**? **Yes / No**

SLEEP-RELATED BREATHING SYMPTOMS

Do you snore? Yes / No How loudly? Mild / Moderate / Loud For how long? ________ months / years

Do you snore while sleeping upright? Yes / No **Do you stop breathing during sleep? Yes / No**

Do you awaken with morning headaches? Yes / No **Do you awaken with dry mouth/sore throat? Yes / No**

PARASOMNIAS/MOVEMENT

Do you now or have you in the past:

Sleepwalk Nightmares or night terrors Kicking during sleep Injured yourself or others during sleep

Performed a complex activity (Driving a car,) without memory Have unusual movements in sleep Fallen out of bed

Physically act out dreams Wet the bed (as an adult) Undesirable sexual behavior during sleep Grind teeth

A Restless sense of discomfort (crawling sensation) in your legs as you are trying to fall asleep Eat in your sleep

If yes, how frequently? _____ per week/month/year (circle one) What age did they begin? _____ years

Please describe: ____

PAST MEDICAL, SURGICAL HISTORY

Have you been diagnosed with (circle):

High Blood Pressure	**Allergies**	**Depression**
Heart Disease	**Sinus infections**	**Anxiety**
Congestive Heart Failure	**Deviated Septum/Broken nose**	**Chronic Pain**
Stroke or TIA	**Asthma**	**Seizures**
High Cholesterol	**COPD / Emphysema**	**Meningitis/Encephalitis**
ADD/ADHD	**Diabetes**	**Serious Head Injury**
Acid Reflux / Hiatal Hernia	**Fibromyalgia**	**Thyroid disease**

Other ____________________ ____________________ ____________________

LIFESTYLE HISTORY

Have you ever smoked cigarettes, cigars or pipe or chew tobacco? Yes / No **If Yes**:

For how many years? _____ Average daily use? _____ If you are no longer using tobacco, when did you quit? _____

How many cups/day do you drink: Caffeinated Coffee ____ Caffeinated Tea ____ Caffeinated Soft Drinks (12 oz) ____

Have you taken prescription or over-the-counter stimulants? **Yes / No** Were these helpful for alertness? **Yes / No**

Do you use marijuana or any other drugs? **Yes / No** If yes, what and how often: ______________________

Did you ever drink alcohol? **Yes / No** Currently? **Yes / No** How many per day (1 glass of wine, 1 shot of liquor, or 1 beer = 1 drink) on **weekdays** (working days)? _____ per day on **weekends** (non-working days)? _____ per day

Have you EVER had the following problems in association with drinking alcoholic beverages?

D.T.'s shakes, hallucinations Detoxification or other treatment

Arrests for drunken driving Family complaints or personal concerns about your drinking

FAMILY AND MEDICAL HISTORY

Did you have any sleep problem as a child? Yes / No Circle all that apply:

Snoring Sleep Apnea Restless Legs Syndrome Sleep Walking Insomnia Excessive Sleepiness

Do other members of your immediate family have any sleep disorders? Yes No **Circle** all that apply:

Snoring Sleep Apnea Restless Legs Syndrome Sleep Walking Excessive Daytime Sleepiness

Insomnia Injuries during sleep Other: ______________________________

(NEXT 4 QUESTIONS ARE FOR WOMEN ONLY) Are you pregnant? **Yes / No**

Have your sleep problems ever varied according to the stage of your menstrual cycle? **Yes / No**

Are you past menopause? Yes No If so, did your sleep change after your menopause? **Yes / No**

SOCIAL HISTORY

Marital Status: _________ **Education highest level:** _______ **Employment Status:** ______________

Current/Past Occupation: __________________ **Is your job at risk because of your sleep problem? Yes / No**

Do you: **Have a commercial drivers license** **Have a pilots license**

Operate heavy/dangerous machinery **Work with nuclear/chemical agents**

PSYCHOLOGICAL HISTORY

Do you feel depressed? Never Rarely Occasionally Frequently Always

Has your sleep problem contributed to a change in mood or personality? **Yes / No** If yes, describe:

____

Have you seen a psychiatrist or any other type of counselor? **Yes / No** Currently? **Yes / No**

Have you been abused? ☐ physically ☐ sexually ☐ emotionally Was the abuse during ☐Childhood or ☐ Adulthood?

REVIEW OF SYSTEMS

Respiratory	**Respiratory (cont')**	**Cardiovascular**	**Neurological**
☐ Shortness of breath ☐ Wheezing ☐ Cough, dry ☐ Cough, productive ☐ Coughing up blood ☐ Oxygen use	☐ Snoring ☐ Stop breathing during sleep ☐ Sleepiness ☐ Diagnosed with sleep apnea/past sleep testing	☐ Chest pain ☐ Murmurs/Valve problems ☐ Muscle pain w/ walking ☐ Leg swelling ☐ Hypertension ☐ Palpitations	☐ Weakness ☐ Seizures ☐ Fainting ☐ Tremor ☐ Problem w/ balance/walking ☐ Numbness or neuropathy
Eyes ☐ Eye redness ☐ Blurry vision ☐ Dry eyes	**Ear, Nose** ☐ Hearing loss ☐ Broken nose ☐ Nose bleeds ☐ Nasal polyps ☐ Recurrent sinusitis	**Mouth, Throat** ☐ Mouth sores ☐ Speech problems ☐ Hoarseness ☐ Swallow difficulty ☐ Painful swallow	**Psychiatric** ☐ Depression ☐ Anxiety ☐ Drug Use or addiction ☐ Alcoholism
Musculoskeletal ☐ Aching muscles ☐ Low back pain ☐ Joint pains ☐ Joint swelling ☐ Joint redness	**Endocrine** ☐ Increased thirst ☐ Cold Intolerance ☐ Hot Flashes Diabetes Thyroid disease	**Genitourinary** ☐ Painful urination ☐ Blood in urine ☐ Urinary frequency ☐ Kidney stones	**Gastrointestinal** ☐ Acid Reflux/heartburn ☐ Abdominal pain ☐ Nausea or vomiting ☐ Liver disease or hepatitis ☐ Blood in stool
Skin/Hair/Breast ☐ Unexplained hair loss ☐ Unexplained Rashes ☐ Eczema ☐ New or changed spots	**Allergic/Immunologic** ☐ Seasonal Allergy ☐ Post nasal drip or hay fever ☐ Frequent Infections	**Heme/Lymphatic** ☐ Swollen lymph nodes ☐ Anemia ☐ Easy Bruising/Bleeding ☐ Blood Transfusions	
Constitutional ☐ Night sweats ☐ Fever ☐ Chills	**Constitutional (cont')** ☐ Weight loss, how much? _________ Over how long? _____months _____years ☐ Weight gain, how much? _________ Over how long? _____months _____years ☐ Loss of appetite ☐ Lack of energy		

TWO WEEK SLEEP DIARY

INSTRUCTIONS:
1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM	
sample	Mon.	Work		E					A				I									C M					
																											week 1
																											week 2