**SLEEP HISTORY QUESTIONNAIRE**

**Welcome to Sleep Center Hawaii!** Your responses in this questionnaire will help our sleep specialist focus on your specific sleep problem. Thank you for your cooperation!

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

PHONE NO: DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EVENINGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_ HEIGHT: \_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER PHYSICIAN YOU WOULD LIKE US TO SEND A REPORT TO:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Is Your Main Sleep Problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is It Getting Worse? **□**No **□**Yes

What Are Others (E.G. Bed Partner) Complaining About? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please Comment On Any Difficulties That Your Sleep Problem Has Caused Or Aggravated At Home, In Your Family, Or At Work.

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

Have You Ever Had A Sleep Study? **□**No **□**Yes If Yes, When? \_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Before Going To Bed Do You:**

Drink Alcoholic Beverages? **□**No **□**Yes If Yes, What And How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Caffeinated Drinks? **□**No **□**Yes If Yes, Please Specify: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soda \_\_\_\_\_

Take A Sleeping Pill? **□**No **□**Yes If Yes, Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Weekdays/Weeknights** | |  | **Weekends** | |
| What Time Do You Go To Bed On Weekdays? |  |  | What Time Do You Go To Bed On Weekends? |  |
| What Time Do You Wake Up On The Weekdays? |  | What Time Do You Wake Up On The Weekends? |  |
| How Many Hours Of Sleep Do You Get? |  | How Many Hours Of Sleep Do You Get? |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please circle the number of the question if your answer is “YES”**.For those questions with a **“YES”** response, **please indicate/estimate how often it occurs per week under “FREQUENCY”** (i.e. "3" means it occurs up to 3 times per week.) | | | | **FREQUENCY** | | |
| 1. Do You Have Trouble Going To Sleep? | | | |  | | |
| 1. Do You Wake Up During The Night? | | | |  | | |
| **2a.** If So, How Many Times A Night? | | | |  | | |
| 1. Do You Wake Up And Have Trouble Going Back To Sleep? | | | |  | | |
| 1. Do You Wake Up Too Early? | | | |  | | |
|  | | | |  | | |
| 1. Do You Get A Nervous Or Restless Feeling In Your Legs That Is Helped By Walking Around Or Moving Your Legs? | | | |  | | |
| 1. Have You Been Told That You Kick Your Legs At Night? | | | |  | | |
| 1. Do You Have Trouble Moving At Night? | | | |  | | |
| 1. Do You Move Too Much At Night? | | | |  | | |
|  | | | |  | | |
| 1. Have You Been Told You Snore? | | | |  | | |
| 1. Do You Stop Breathing At Night? | | | |  | | |
| 1. Do You Wake Up Gasping Or Feeling Like You Can’t Breathe? | | | |  | | |
| 1. Do You Wake Up With A Headache? | | | |  | | |
| 1. Does Your Heart Beat Fast When You Wake Up? | | | |  | | |
| 1. Do You Wake Up With A Sour Or Dry Taste In Your Mouth? | | | |  | | |
|  | | | |  | | |
| 1. Do You Dream Soon After Lying Down To Sleep? | | | |  | | |
| 1. Do You See Or Hear Things That Are Not There Before Falling Asleep? | | | |  | | |
| 1. Do You Feel Like You Cannot Move Soon After Lying Down To Sleep Or Before You Awaken Completely? | | | |  | | |
| 1. Do You Ever Feel Sudden Weakness In Your Knees Or Other Body Parts When Laughing, Angry, Sad, Or Emotional? | | | |  | | |
| 1. Do You Ever Find Yourself Somewhere And Not Remember How You Got There? | | | |  | | |
|  | | | |  | | |
| 1. Do You Sleep Walk? | | | |  | | |
| 1. Do You Have Bad Nightmares? | | | |  | | |
| 1. Do You Have A Bedwetting Problem? | | | |  | | |
| 1. Do You Act Out Your Dreams? | | | |  | | |
| 1. Do You Talk In Your Sleep? | | | |  | | |
| 1. Do You Grind Your Teeth At Night? | | | |  | | |
|  | | | |  | | |
| 1. Do Sleep With More Than One Pillow? | | | |  | | |
| 1. Do You Urinate More Than Once At Night? | | | |  | | |
| 1. Does Pain Disturb Your Sleep? | | | |  | | |
| 1. Does Noise/Light Disturb Your Sleep? | | | |  | | |
| 1. Do You Wake Up Feeling Tired, Disoriented, Or Foggy? | | | |  | | |
| 1. Do You Feel Extremely Sleepy During The Day? | | | |  | | |
| 1. Do You Take Naps On Purpose During The Day? | | | |  | | |
|  | |  | | |
| The following is a scale to assess the degree of your daytime sleepiness. Please use the **one most appropriate number** to describe how likely you are to doze off in 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** | | |
| 1. Sitting And Reading | | |  | | |
| 1. Watching T.V. | | |  | | |
| 1. Sitting, Inactive In Public, (E.G. At A Meeting Or In A Theater) | | |  | | |
| 1. As A Passenger In A Car For An Hour Without A Break? | | |  | | |
| 1. Lying Down To Rest In The Afternoon? | | |  | | |
| 1. Sitting And Talking To Someone? | | |  | | |
| 1. Sitting Quietly After Lunch Without Alcohol? | | |  | | |
| 1. In A Car While Stopped For A Few Minutes In Traffic? (Non-Drivers Should Answer When They Are On The Subway/Bus/Taxi) | | |  | | |
| **PLEASE TOTAL YOUR SCORE** | | |  | | |

**Please Indicate Which Of The Following Medical Conditions Applies To You:**

|  |  |  |  |
| --- | --- | --- | --- |
| **□**TROUBLE CONCENTRATING  **□**FORGETFULNESS  **□**TROUBLE SEEING OR HEARING  **□**TROUBLE MOVING  **□**TROUBLE FEELING  **□**TROUBLE WITH BALANCE  **□**HEADACHES  **□**FAINTING  **□**SEIZURES | **□**CHEST PAINS  **□**HEART RACING  **□**NAUSEA  **□**VOMITING  **□**CONSTIPATION  **□**DIARRHEA  **□**BURNING WHEN URINATING  **□**BLOOD IN URINE | **□**JOINT PAIN  **□**JOINT SWELLING  **□**MUSCLE TWITCHING  **□**SKIN RASH  **□**WEIGHT LOSS  **□**WEIGHT GAIN  **□**DEPRESSION  **□**ANXIETY | **□**EMPHYZEMA  **□**CHRONIC BRONCHITIS  **□**ASTHMA  **□**MUSCLE DISEASE  **□**THYROID DISEASE  **□**DIABETES  **□**HEART DISEASE  **□**HIGH BLOOD PRESSURE |

Have You Gained Weight In The Last 10 Years? **□**No **□**Yes If Yes, How Many Pounds? \_\_\_\_\_\_\_\_\_\_

Have You Had Your Tonsils Removed? **□**No **□**Yes If Yes, When? (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_

Have You Had Major Surgeries Or Hospitalizations? **□**No **□**Yes

If Yes, When And What Kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Had Any Serious Injuries? **□**No **□**Yes

If Yes, When And What Kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Provide Details For Any Illness You Have Circled Or Any That Is Not Listed:

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

Do You Have Any Allergies? **□**No **□**Yes If Yes, Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Take Medications? **□**No **□**Yes If Yes Please List Names, Dosage, And Reason For Taking Them (e.g. blood pressure):

|  |  |  |
| --- | --- | --- |
| **NAME** | **DOSAGE** | **REASON TAKEN** |
|  |  |  |
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Did Tests (E.G. Blood Work X-Rays) Done at Another Physician’s Office Show any Abnormalities? **□**No **□**Yes

If Yes, Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Anyone In Your Family (Blood Relatives Only) Have A History Of The Same Sleep Problems As You Have? **□**No **□**Yes

If Yes, Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You: **□**Married **□**Single **□**Divorced **□**Separated **□**Widowed

What Is Your Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where Do You Work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What Hours Do You Work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Sleep: **□** With Someone in the Same Bed? **□**With Someone In The Same Room? OR **□**Alone?

Do You Have Sexual Problems? **□**No **□**Yes

Do You Use Drugs?  **□**Marijuana **□**Cocaine **□**Heroin **□**Other **□**None

Do You Smoke Cigarettes? **□**No **□**Yes If So, How Much? \_\_\_\_\_Pack/\_\_\_\_\_Day

What Do You Like To Do In Your Spare Time? (Hobbies, Crafts, Organizations, Clubs, AND Sports)?

Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What Is The Kind And Total Amount Of Alcohol You Drink (If Any) In A 24 Hour Period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How Many Cups or Cans Of The Following Caffeinated Beverages Do You Drink In An Average 24 Hour Period?

Coffee \_\_\_\_\_\_\_\_\_\_\_ Tea \_\_\_\_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_\_\_ Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Add Any Comments Or Problems Not Listed In This Questionnaire:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**THANK YOU FOR COMPLETING OUR QUESTIONNAIRE!**

**The following is for the physician’s use only.**

BP: \_\_\_\_\_\_\_\_ HR: \_\_\_\_\_\_\_\_ RESP. RATE: \_\_\_\_\_\_\_\_\_ HEENT: \_\_\_\_\_\_\_\_\_\_ REFLEXES: \_\_\_\_\_

Imp: Plan: