SLEEP CENTER HAWAII

DATE:_____

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

What Time Do You Go To Bed On Weekdays?	
What Time Do You Wake Up On The Weekdays?	
How Many Hours Of Sleep Do You Get?	

Weekends

What Time Do You Go To Bed On Weekends?	
What Time Do You Wake Up On The Weekends?	
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?	
2. Do You Wake Up During The Night?	
2a. If So, How Many Times A Night?	
3. Do You Wake Up And Have Trouble Going Back To Sleep?	
4. Do You Wake Up Too Early?	
5. Do You Get A Nervous Or Restless Feeling In Your Legs That Is Helped By Walking Around Or Moving Your Legs?	
6. Have You Been Told That You Kick Your Legs At Night?	
7. Do You Have Trouble Moving At Night?	
8. Do You Move Too Much At Night?	
9. Have You Been Told You Snore?	
10. Do You Stop Breathing At Night?	
11. Do You Wake Up Gasping Or Feeling Like You Can't Breathe?	
12. Do You Wake Up With A Headache?	
13. Does Your Heart Beat Fast When You Wake Up?	
14. Do You Wake Up With A Sour Or Dry Taste In Your Mouth?	
15. Do You Dream Soon After Lying Down To Sleep?	
16. Do You See Or Hear Things That Are Not There Before Falling Asleep?	
17. Do You Feel Like You Cannot Move Soon After Lying Down To Sleep Or Before You Awaken Completely?	
18. Do You Ever Feel Sudden Weakness In Your Knees Or Other Body Parts When Laughing, Angry, Sad, Or Emotional?	
19. Do You Ever Find Yourself Somewhere And Not Remember How You Got There?	
20. Do You Sleep Walk?	
21. Do You Have Bad Nightmares?	
22. Do You Have A Bedwetting Problem?	
23. Do You Act Out Your Dreams?	
24. Do You Talk In Your Sleep?	
25. Do You Grind Your Teeth At Night?	
26. Do Sleep With More Than One Pillow?	
27. Do You Urinate More Than Once At Night?	
28. Does Pain Disturb Your Sleep?	
29. Does Noise/Light Disturb Your Sleep?	
30. Do You Wake Up Feeling Tired, Disoriented, Or Foggy?	
31. Do You Feel Extremely Sleepy During The Day?	
32. 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	
2. Watching T.V.	
3. Sitting, Inactive In Public, (E.G. At A Meeting Or In A Theater)	
4. As A Passenger In A Car For An Hour Without A Break?	
5. Lying Down To Rest In The Afternoon?	
6. Sitting And Talking To Someone?	
7. Sitting Quietly After Lunch Without Alcohol?	
8. 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	☐ CHEST PAINS	☐ JOINT PAIN	☐ EMPHYZEMA
☐ FORGETFULNESS	☐ HEART RACING	☐ JOINT SWELLING	☐ CHRONIC BRONCHITIS
☐ TROUBLE SEEING OR HEARING	☐ NAUSEA	☐ MUSCLE TWITCHING	☐ ASTHMA
☐ TROUBLE MOVING	☐ VOMITING	☐ SKIN RASH	☐ MUSCLE DISEASE
☐ TROUBLE FEELING	☐ CONSTIPATION	☐ WEIGHT LOSS	☐ THYROID DISEASE
☐ TROUBLE WITH BALANCE	☐ DIARRHEA	☐ WEIGHT GAIN	☐ DIABETES
☐ HEADACHES	☐ BURNING WHEN URINATING	☐ DEPRESSION	☐ HEART DISEASE
☐ FAINTING	☐ BLOOD IN URINE	☐ ANXIETY	☐ HIGH BLOOD PRESSURE
☐ SEIZURES			

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 Any Hospitalizations? ☐No ☐Yes … Or Any Major Surgeries? ☐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

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?

_____

_____

_____

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:

_____

_____

_____

THANK YOU FOR COMPLETING OUR QUESTIONNAIRE!

The following is for the physician's use only.

HT: WT: BMI: SPO2: NECK: TEMPT:

BP: _____ HR: _____ RESP. RATE: _____ HEENT: _____ REFLEXES: _____

Imp: Plan: