

SLEEP HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

1 What problems are you having with your sleep?

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

At which medical facility was the diagnosis made?

3 Do you keep a fairly regular sleep/wake schedule? Yes No

4 What time do you usually go to bed on weekdays or days that you work? _____

5 What time do you usually wake up on days that you work? _____

6 What time do you usually go to bed on weekends or non work days? _____

7 What time do you usually wake up on weekends or non work days? _____

8 Do you usually feel well rested upon awakening? Yes No
 If no, how do you feel?

9 How many hours do you usually sleep?
 Weekdays/Workdays
 Weekends/Non-Work Days

10 On week days or work days, do you nap during the day? Yes No
 If yes, what are the number of naps and average lengths? _____

11 On weekends or non-work days, do you nap during the day? Yes No
 If yes, what are the number of naps and average lengths? _____

12 Do you watch TV in bed? Yes No

13 Do you look at your bedroom clock at night? Yes No

14 Do you have arguments in bed? Yes No

15 Do you eat in bed? Yes No

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|---|-----|----|
| 16 Do you worry in bed? | Yes | No |
| 17 Do you currently do shift work? | Yes | No |
| 18 Have you done shift work in the past? | Yes | No |
| 19 If yes to 18-19, do you have trouble sleeping when you are doing shift work? | Yes | No |
| 20 Does your spouse perform shift work?
If yes, please explain. | Yes | No |

(Answer the following questions assuming "night" means your major sleeping time.)

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|--|-------|----|
| 21 Do you often have trouble getting to sleep at night? | Yes | No |
| 22 What is the average number of minutes it takes you to fall asleep at night? | <hr/> | |
| 23 Do you often have awakenings at night?
If yes, what is the average number of times you wake and why? | Yes | No |
| <hr/> | | |
| 24 Do you have long periods when you awaken and are not able to go back to sleep? | Yes | No |
| 25 Are you bothered by waking up too early and not being able to go back to sleep?
If yes, how long are these periods of wakefulness when added together? | Yes | No |
| <hr/> | | |

MOVEMENT

- | | | |
|--|-----|----|
| 26 Do you awaken yourself by kicking your legs or other sudden movements during the night? | Yes | No |
| 27 Has your bed partner ever complained of your legs kicking or other sudden movements? | Yes | No |
| 28 Did you have sleep problems as a child? | Yes | No |
| 29 Do you currently have nightmares or night terrors? | Yes | No |
| 30 Do you grind your teeth at night? | Yes | No |
| 31 Did you frequently wet the bed as a child? | Yes | No |
| 32 Did you ever wet the bed as an adult? | Yes | No |
| 33 Have you ever been told that you walk in your sleep? | Yes | No |
| 34 Have you recently walked in your sleep? | Yes | No |

- 35 Have you ever been told you make unusual movements such as talking, swinging arms about, acting out dramas, etc. during sleep? Yes No
- 36 Do you feel excessively sleeping in the daytime? Yes No
- 37 Do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes No
- 38 Have you ever felt sudden muscle weakness when you laughed or got angry? Yes No
If yes, describe:
-
- 39 Have you ever been unable to move your body just as you were falling asleep or waking? Yes No
- 40 Have you ever had exceptionally vivid dreams just as you were falling asleep or waking? Yes No
- 41 Have you ever had a driving accident or near accident due to falling asleep? Yes No
- 42 Have people who have shared your bedroom told you that you snore?
Never Rarely Occasionally I don't Know Yes No
- 43 Can your snoring be heard through closed doors? Yes No
- 44 Have you been told by other people that you gasp, choke or snort while you're sleeping?
Never Rarely Occasionally I don't Know Yes No
- 45 Have you ever been told that you stop breathing during your sleep? Yes No
- 46 Do you wake up with morning headaches?
Never Monthly Weekly Daily Yes No
- 47 Do you awaken with a dry mouth or sore throat? Yes No
- 48 Do you awaken with choking or gasping sensation? Yes No
- 49 Does your sleep position affect your snoring? Yes No
- 50 Do you have difficulty breathing through your nose? Yes No
- 51 Have you ever had surgery on your upper airway? Yes No
- 52 To the best of your recollection, indicate your weight history?
- | | |
|-----------|------|
| At age 20 | lbs. |
| At age 30 | lbs. |
| At age 40 | lbs. |
| At age 50 | lbs. |
| At age 60 | lbs. |
- 53 What was your heaviest weight and at what age?
- | | |
|--|------|
| | lbs. |
| | age |

