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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

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.)

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?		
23	Do you often have awakenings at night? If yes, what is the average number of times you wake and why?	Yes	No
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

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

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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? Yes No
Never Rarely Occasionally I don't Know

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? Yes No
Never Rarely Occasionally I don't Know

45 Have you ever been told that you stop breathing during your sleep? Yes No

46 Do you wake up with morning headaches? Yes No
Never Monthly Weekly Daily

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

Family History

54 Do members of your immediate family snore or have they been diagnosed with sleep disorders? Yes No

55 Do members of your immediate family have excessive daytime sleepiness? Yes No

56 Have you ever smoked cigarettes? Yes No
If yes, do you currently smoke cigarettes? Yes No
If no, when did you quit and how much were you smoking?

_____

57 Have you ever smoked cigars? Yes No

58 Have you ever chewed tobacco? Yes No

59 Have you ever smoked a pipe? Yes No

60 How many cups of caffeinated coffee do you drink per day? _____

61 How many caffeinated soft drinks do you drink per day? _____

62 Do you currently smoke marijuana or take illicit drugs? Yes No

63 Do you currently drink alcohol? Yes No
If yes, on average, how much: Weekdays _____
Weekends _____

64 Do you have any other comments about your sleep?

_____

_____