Sleep History Questionnaire

Name: ____ Date: ________________________

Date of birth: ________ Age:_____ Ht. _____ Wt. _____ Gender: Male/ Female (circle)

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 estimate how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = **Neve**r doze **1** = **Slight** chance of dozing **2** = **Moderate** chance of dozing **3** = **High** chance of dozing

Situations:	Chance of Dozing
☾ Sitting and reading	
☾ Watching TV	
☾ Sitting, inactive in a public place (i.e., a theater 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 with someone	
☾ Sitting quietly after a lunch without alcohol	
☾ In a car, while stopped for a few minutes in traffic	
Total:	_____________

1. Describe your main problem(s), including when and how this began and what treatment you have received for this in the past.

2. How often does this problem occur?
   - ☐ Almost every night
   - ☐ For periods of at least a week
   - ☐ Irregularly
   - ☐ Other ____

3. How long has this problem bothered you?
   - ☐ Longer than 2 years
   - ☐ 1 to 2 years
   - ☐ Several months
   - ☐ Within the last 3 months
   - ☐ Within the last month

4. On the scale below, please estimate the severity of your problem(s).
   - ☐ Mildly Upsetting ☐ Moderately Severe ☐ Very Severe
   - ☐ Extremely Severe ☐ Totally Incapacitating

5. How strongly do you want help with your problem?
   ☐ Very Much ☐ Much ☐ Moderately ☐ Could do without it

6. How do you describe your sleep problem? Check all that apply to you.
   ☐ Difficulty falling asleep
   ☐ Wake up during the night
   ☐ Wake up early in the morning
   ☐ Excessive daytime sleepiness
   ☐ Difficulty awakening

7. Do any other members of your family have sleep problems? Please explain:
   ____

8. Have you previously consulted with a physician to help with a sleep problem?____________________
   ____

9. Have you previously received any treatments for sleep problems?________________

10. Please rate how often you:

N = Never R = Rarely O = Occasionally F = Frequently C = Constantly

Awaken from sleep short of breath:	N	R	O	F	C
Awaken at night with heartburn, belching or coughing	N	R	O	F	C
Snore	N	R	O	F	C
Snore loudly enough that others complain	N	R	O	F	C
Have trouble sleeping when you have a cold	N	R	O	F	C
Suddenly wake up gasping for breath during the night	N	R	O	F	C
Have breathing problems at night (observed by self or others)	N	R	O	F	C
Sweat excessively at night	N	R	O	F	C
Notice your heart pounding or beating irregularly during the night	N	R	O	F	C
Fall asleep during the day	N	R	O	F	C
Fall asleep involuntarily	N	R	O	F	C
Fall asleep while driving	N	R	O	F	C
Fall asleep during physical activity	N	R	O	F	C
Fall asleep when laughing or crying	N	R	O	F	C
Experience loss of muscle tone when extremely emotional	N	R	O	F	C
Have trouble at school or work because of sleepiness	N	R	O	F	C
Feel unable to move (paralyzed) when waking or falling asleep	N	R	O	F	C
Experience vivid dreamlike scenes awakening or falling asleep	N	R	O	F	C
Feel afraid of going to sleep	N	R	O	F	C
Have nightmares	N	R	O	F	C

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Remember your dreams	N	R	O	F	C
Have thoughts racing through your mind	N	R	O	F	C
Feel sad or depressed	N	R	O	F	C
Have anxiety (worry about things)	N	R	O	F	C
Have muscular tension	N	R	O	F	C
Notice parts of your body jerk	N	R	O	F	C
Kick during the night	N	R	O	F	C
Experience crawling and aching feelings in your legs	N	R	O	F	C
Experience any type of leg pain during the night	N	R	O	F	C
Having morning jaw pain	N	R	O	F	C
Grind teeth during sleep	N	R	O	F	C
Are bothered by pain during the day	N	R	O	F	C
Are awakened by pain during the night	N	R	O	F	C
Wake up feeling stiff in the morning	N	R	O	F	C
Wake up with sore or achy muscles	N	R	O	F	C
Wake up with pain in neck, spine or joints	N	R	O	F	C
Heartburn at night?	N	R	O	F	C
Morning headaches?	N	R	O	F	C
Awake refreshed?	N	R	O	F	C
Memory or concentration problems?	N	R	O	F	C

12. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?____

13. How many hours of sleep do you usually get per night? ______________________________

14. What time do you usually go to bed on: WEEKDAYS? _______________WEEKENDS?____________

15. How long does it take for you to fall asleep? ____

16. How many times do you typically wake up at night? ____

17. If you wake up, on the average, how long do you stay awake? _______________________________

18. If you do awaken during the night (after you first fall asleep) which part(s) of your sleep period is it
☐ Soon after falling asleep ☐ Early morning ☐ Middle of the night

19. What do you usually do when you awaken during the night? ________________________________

23. What time do you usually awaken in the morning on: Weekdays? ________ Weekends? _______

24. On the average, how long do you stay in bed after waking in the morning? _________(hours/minutes)

25. Do you usually: (Check all that apply to you)
    - ☐ Sleep with someone else in your bed
    - ☐ Sleep with someone else in your room
    - ☐ Provide assistance to someone during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by:

☐ heat	☐ cold	☐ noise
☐ light	☐ bed partner	☐ not being your usual bed
☐ other ______________________________________		

27. With whom are you now living? (wife, husband, children, parents, etc., please list ages)
    ____

28. Do you work split shifts or rotating (variable) shifts? ______________________________

29. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐ Yes ☐ No

30. Do you do physical exercise before bedtime? ☐ Yes ☐ No

31. Do you read before falling asleep? ☐ Yes ☐ No

32. Do you watch TV in bed before falling asleep? ☐ Yes ☐ No

33. Do you take naps during the afternoon or evening? ☐ Yes ☐ No

34. Do you feel refreshed after a short (10-15 minute) nap? ☐ Yes ☐ No

35. How do you feel after an average night of sleep?
    - ☐ Un-rested/ tired
    - ☐ Rested most of the time
    - ☐ Consistently rested and refreshed

36. When do you feel most alert? ☐ Morning ☐ Afternoon ☐ Evening

37. List your consumption of the following per day:

    Cigarettes Yes____(packs per day)_______ Never__________Used to ____Months/Years Ago

    Caffeine Yes____ No____ Quantity (Beverages/Day) ______________

    Alcohol Yes____ No____ Quantity (Beverages/Day)______________

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Sleep Disorders Center
Lincoln, NE

MEDICAL HISTORY

38. Have you now, or have you in the past experienced any health problems associated with the areas listed?

Yes No

☐ ☐ Mental Health: ______________________________

☐ ☐ Nervous System: ______________________________

☐ ☐ Ears, Eyes, Nose, Throat: ______________________________

☐ ☐ Breathing: ______________________________

☐ ☐ Stomach: ______________________________

☐ ☐ Bowels: ______________________________

☐ ☐ Urinary or Kidney: ______________________________

☐ ☐ Hormones: ______________________________

☐ ☐ Heart/Circulation: ______________________________

☐ ☐ Chronic pain: ______________________________

☐ ☐ Allergies: ______________________________

☐ ☐ Surgeries: ______________________________

NAME OF MEDICATION	AMOUNT TAKEN	HOW OFTEN	REASON

39. Have you had recent weight gains or loss? Please explain.______________________________

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