PULMONARY AND INTENSIVE CARE SPECIALISTS OF NEW JERSEY

Sleep History Questionnaire

Name: _____ Date: _____

Birthdate: _____ Age: _____ Occupation: _____

Sex: _____Height: _____ Weight: _____ Weight Last Year: _____

Referring Doctor: _____ Family Doctor: _____

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Describe your sleep problem: _____

_____

What results do you expect: _____

_____

A. MEDICATION SURVEY

Please list all PRESCRIPTION and NON-PRESCRIPTION medications you're currently taking.

MEDICATION	REASON TAKEN	DOSE

ALLERGIES: _____

B. PLEASE LIST ALL PAST OR PRESENT *MEDICAL CONDITIONS* OR *SURGERIES*

C. SLEEP PATTERN

1. Circle the days of the week you work:

   Monday Tuesday Wednesday Thursday Friday Saturday Sunday

2. *ON WORKDAYS*
   a. What time do you go to bed: _____
   b. What time do you get out of bed: _____
3. *ON WEEKENDS & HOLIDAYS*
   a. What time do you go to bed: _____
   b. What time do you get out of bed: _____
4. How long does it take for you to fall asleep? _____
5. How many times a night do you awaken? _____
   a. How long do the awakenings last? _____
   b. List any symptoms associated with the awakenings: _____
   _____
6. *SLEEP TIME*
   a. How many hours do you usually sleep? _____
   (do not include hours spent in bed awake)
   b. How many hours does it take to make you feel rested? _____
   c. How many daytime naps do you take per week? _____
7. *SLEEP QUALITY*
   a. Do you feel unrefreshed and still sleepy upon awakening? **YES** **NO**
   b. How long does it take to fully awaken in the morning? _____
8. In the daytime, are you chronically sleepy, fatigued or tired? **YES** **NO**
9. Grade your tendency to <u>*FALL ASLEEP*</u> during the following situations:
   (0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

	0	**1**	**2**	**3**
a. Sitting and reading				
b. Watching TV				
c. Sitting inactive in a public place (e.g. theater or meeting)				
d. As a passenger in a car for an hour without a break				
e. Lying down to rest in the afternoon				
f. Sitting and talking to someone				
g. Sitting quietly after lunch without alcohol				
h. In a car, while stopped for a few minutes				

D. SLEEP AND BREATHING

1. Do you snore?	**YES**	**NO**
2. Is your snoring broken by hesitations, gasps and snorts?	**YES**	**NO**
3. Are the hesitations long enough to frighten your sleep partner?	**YES**	**NO**
4. Has your snoring driven your bed partner from the bedroom?	**YES**	**NO**
5. Do you awaken with a dry mouth?	**YES**	**NO**
6. Do you awaken with headaches?	**YES**	**NO**

E. INSOMNIA

1. Do you have trouble falling or staying asleep?	**YES**	**NO**
2. Do you worry about being able to fall asleep on time?	**YES**	**NO**
3. Do you feel sleepy prior to getting into bed?	**YES**	**NO**
4. Does your mind race with thoughts when lying awake?	**YES**	**NO**
5. Do daytime worries keep you awake at night?	**YES**	**NO**
6. Does pain disturb your sleep?	**YES**	**NO**
7. Does heat, cold, hunger or thirst disturb your sleep?	**YES**	**NO**
8. Is your insomnia the primary reason your life is in disarray?	**YES**	**NO**
9. Do you rely on a sleeping medication?	**YES**	**NO**
10. Do you watch TV, read, or work in bed?	**YES**	**NO**
11. Do you frequently travel across 2 or more time zones?	**YES**	**NO**

F. SLEEP DISTURBANCES

1. Do you experience unpleasant leg sensations at bedtime?	**YES**	**NO**
2. Do you kick or jerk your legs and/or arms during sleep?	**YES**	**NO**
3. Do you have sweats or awaken from sleep feeling flushed?	**YES**	**NO**
4. Do you awaken with a bitter or acid taste?	**YES**	**NO**
5. Do you frequently have nightmares or vivid dreams?	**YES**	**NO**
6. Do you grind your teeth or have bitten your cheek during sleep?	**YES**	**NO**
7. Have you ever walked or talked in your sleep?	**YES**	**NO**
8. Have you ever been unable to move for a few moments after awakening?	**YES**	**NO**
9. Have you ever seen or felt things from your dreams *after* awakening?	**YES**	**NO**
10. Have you ever experienced weakness when laughing or angry?	**YES**	**NO**
11. Have you ever had unusual movements or behaviors during sleep?	**YES**	**NO**

Describe: _____

G. PERSONAL HABITS

1. Do you use tobacco now or have you in the *past*?	**YES**	**NO**
a. If yes, how many per day and for how many years? _____		
b. If yes, what time of day is your last use? _____		
2. Do you drink alcohol?	**YES**	**NO**
a. If yes, how many drinks? _____ per day / per week / per month (circle one).		
b. If yes, what time of day is your last drink? _____		
3. How many caffeinated beverages do you drink per day? _____		
a. If yes, what time of day is your last drink? _____		

H. FAMILY HISTORY

	AGE	MEDICAL CONDITIONS
Father:	_____	_____
Mother:	_____	_____
Sibling 1:	_____	_____
Sibling 2:	_____	_____
Sibling 3:	_____	_____

(continue below if necessary)

1. List any relatives who have sleep problems or snore?

_____ _____

_____ _____

I. PERSONAL HISTORY (Check any and all that apply)

☐ skipped heart beats	☐ heart failure	☐ heart attack	☐ heart murmur
☐ high blood pressure	☐ thyroid problems	☐ diabetes	☐ stroke
☐ epilepsy	☐ headaches	☐ emphysema	☐ sinusitis
☐ nasal congestion	☐ deviated nasal septum	☐ enlarged tonsils	☐ allergies
☐ asthma	☐ glaucoma	☐ depression/anxiety	☐ Bipolar disorder

J. BED PARTNER QUESTIONNAIRE (Please have your bed partner check any and all that apply)

☐ Light snoring	☐ Sleep walking	☐ Leg or body twitching
☐ Heavy snoring	☐ Sleep talking	☐ Leg jerking
☐ Pauses in breathing	☐ Bed-wetting	☐ Daytime sleepiness
☐ Snorting	☐ Head rocking/banging	☐ Daytime confusion
☐ Teeth grinding	☐ A shaking fit	☐ Depression/anxiety

1. Provide additional detail regarding any of the above. Please describe the activity, the time it occurs, and how often it occurs.

_____

_____

_____

K. ADDITIONAL INFORMATION

_____

_____

_____