

**SLEEP/WAKE DISORDERS CENTER**  
*Accredited by the American Academy of Sleep Medicine*

**Please complete this questionnaire and bring it with you to your appointment.**

***Sleep history questionnaire:***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Additional Doctors to send sleep/wake test results to: \_\_\_\_\_

E-mail address: \_\_\_\_\_

***Medical History:***

What was your weight:

6 months ago \_\_\_\_\_ 2 years ago \_\_\_\_\_ High School \_\_\_\_\_

Do you smoke?  Yes  No If so, how many packs per day? \_\_\_\_\_

How many cups of coffee, or caffeinated soft drinks, do you drink on an average day? \_\_\_\_\_

Do any of your immediate family members have a sleep disorder?  Yes  No

If so what kind? \_\_\_\_\_

Month/Year of last hospitalization: \_\_\_\_\_ / \_\_\_\_\_ For what problem? \_\_\_\_\_

Current medications: (Please list: name, strength, and how the medication is taken)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any food and medication allergies you have:

\_\_\_\_\_  
\_\_\_\_\_



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### A few simple guidelines:

- The following questions will help us to better understand your sleep/wake behavior and problems, and more accurately interpret the results of your sleep/wake testing. It is important for you to answer each question as completely and accurately as you can.
- Some of the questions might be better answered by someone else (e.g. your spouse, roommate, partner, family member.) Please get their input as well.
- Do not spend too much time on any question. Your first impression is generally the most accurate.
- The time period referred to is the PRESENT, which includes the last 6 months, unless otherwise specified.
- A "WEEKDAY" is any day on which you ordinarily work.
- If you are engaged in shift work, or have any type of unusual sleep/wake schedule other than "DAYTIME" and "NIGHTTIME", refer to your particular major sleeping and waking periods.
- All answers will be kept confidential.

**Occupation:** \_\_\_\_\_

Your present work schedule is best described as:

Unemployed    Days    Evenings    Nights    Rotating

Your work shift starts at: \_\_\_\_\_ a.m.   \_\_\_\_\_ p.m.

Your work shift ends at: \_\_\_\_\_ a.m.   \_\_\_\_\_ p.m.

### Your current sleep schedule:

What time do you usually go to bed?

**Week Days**

**Week Ends**

\_\_\_\_\_

\_\_\_\_\_

How long does it usually take for you to go to sleep?

\_\_\_\_\_

\_\_\_\_\_

What time do you usually get up?

\_\_\_\_\_

\_\_\_\_\_

### Questions about your current sleep:

#### How often do you:

**Never**

**Sometimes**

**Always**

Sleep soundly?




Have frequent brief awakenings?




Have difficulty going to sleep?




Wake up early in the morning and can't go back to sleep?




Experience restless legs? (crawling, aching sensation in legs relieved by movement)




Have periodic body movements during sleep?




Have restless disturbed sleep?




Disturb your partner's sleep because of snoring?




Stop breathing in your sleep?





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	<b>Never</b>	<b>Sometimes</b>	<b>Always</b>
Awaken from sleep due to choking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken from sleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken from sleep to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken screaming, violent or confused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically act out your own dreams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel anxious about inability to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel unable to move (paralyzed) for a few minutes upon awakening or going to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience dream-like images (hallucinations) upon awakening even though you know that you are awake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a headache upon awakening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other problems with your sleep? (Please describe)			

**Questions about your current ability to stay alert:**

<b><i>How great of a problem do you have:</i></b>	<b>Never</b>	<b>Sometimes</b>	<b>Always</b>
Staying awake and alert during the day ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With attention and mental focus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying awake while inactive (e.G. Reading)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing your job because of drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving because of drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***During the past 6 months, how often have you had:***

	<b>Never</b>	<b>Sometimes</b>	<b>Always</b>
Spontaneous episodes of unintentionally falling to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any near-accidents because of sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any actual accidents due to sleepiness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many? _____

***How often do you:***

	<b>Never</b>	<b>Sometimes</b>	<b>Always</b>
Experience vivid dreams during naps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform a complex act such as driving a car to the wrong destination and not remember how you did it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a sudden feeling of weakness come over you when you laugh, are angry or excited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel "weak knees" when you laugh?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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What is your personal interpretation as to why you have your particular sleep/wake problem?

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**Epworth Sleepiness Scale:**

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 decide how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. 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 to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total:	

**Homecare Company Referrals:**

In the event that you should require the service of a home care company, we will refer you to Community Home Health Services. If they are not a provider covered by your insurance, another selection will be necessary for insurance approval. If you have a personal preference for a homecare company, please list below.

Preferred Homecare Company: \_\_\_\_\_

