



Welcome to the Guam Sleep Center. Filling out this questionnaire will help your doctor focus on your specific sleep problem. Thank you for your cooperation!

SLEEP HISTORY QUESTIONNAIRE

PATIENT NAME: _____

ADDRESS: _____

PHONE NO: DAY: _____ EVENINGS: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

OTHER PHYSICIAN YOU WOULD LIKE US TO SEND A REPORT TO:

NAME: _____ PHONE: _____

ADDRESS: _____

WHAT IS YOUR MAIN SLEEP PROBLEM? _____

WHEN DID THIS PROBLEM BEGIN? _____

IS IT GETTING WORSE? YES NO

WHAT DO OTHERS (e.g. BED PARTNER) COMPLAIN ABOUT? _____

PLEASE COMMENT ON ANY DIFFICULTIES THAT YOUR SLEEP PROBLEM HAS CAUSED OR AGGRAVATED AT HOME, IN YOUR FAMILY, OR AT WORK. _____

HAVE YOU EVER HAD A SLEEP STUDY? YES NO

IF YES, WHEN? _____ RESULTS: _____

WHAT TIME DO YOU GO TO BED ON WEEKDAYS? _____
WHAT TIME DO YOU WAKE UP ON WEEKDAYS? _____
HOW MANY HOURS OF SLEEP DO YOU GET ON WEEKNIGHTS? _____

WHAT TIME DO YOU GO TO BED ON WEEKENDS? _____
WHAT TIME DO YOU GET UP ON WEEKENDS? _____
HOW MANY HOURS OF SLEEP DO YOU GET ON THE WEEKENDS? _____

BEFORE GOING TO BED DO YOU:

DRINK ALCOHOLIC BEVERAGES? NO ____ YES ____

IF YES, WHAT AND HOW MUCH? _____

DRINK CAFFEINATED DRINKS? NO ____ YES ____ IF YES: COFFEE ____ TEA ____ SODA ____

TAKE A SLEEPING PILL? NO ____ YES ____ IF YES, PLEASE SPECIFY: _____

- PLEASE **CIRCLE THE NUMBER** NEXT TO THE QUESTION IF YOUR ANSWER IS YES".
- FOR THOSE QUESTIONS, UNDER FREQUENCY, INDICATE **HOW OFTEN** THE PROBLEM OCCURS **EACH WEEK**.

FREQUENCY

1. DO YOU HAVE TROUBLE GOING TO SLEEP? _____
2. DO YOU WAKE UP DURING THE NIGHT? _____
 - HOW MANY TIMES A NIGHT? _____
3. DO YOU WAKE UP AND HAVE TROUBLE GOING BACK TO SLEEP? _____
4. DO YOU WAKE UP TOO EARLY? _____

5. DO YOU GET A NERVOUS OR RESTLESS FEELING IN YOUR LEGS THAT IS HELPED BY WALKING AROUND OR MOVING YOUR LEGS? _____
6. HAVE YOU BEEN TOLD THAT YOU KICK YOUR LEGS AT NIGHT? _____
7. DO YOU HAVE TROUBLE MOVING AT NIGHT? _____
8. DO YOU MOVE TOO MUCH AT NIGHT? _____

9. HAVE YOU BEEN TOLD YOU SNORE? _____
10. DO YOU STOP BREATHING AT NIGHT? _____
11. DO YOU WAKE UP GASPING OR FEELING LIKE YOU CAN'T BREATHE? _____
12. DO YOU WAKE UP WITH A HEADACHE? _____
13. DOES YOUR HEART BEAT FAST WHEN YOU WAKE UP? _____
14. DO YOU WAKE UP WITH A SOUR OR DRY TASTE IN YOUR MOUTH? _____

15. DO YOU DREAM SOON AFTER LYING DOWN TO SLEEP? _____
16. DO YOU SEE OR HEAR THINGS THAT ARE NOT THERE BEFORE FALLING ASLEEP? _____
17. DO YOU FEEL LIKE YOU CANNOT MOVE SOON AFTER LYING DOWN TO SLEEP OR BEFORE YOU AWAKEN? _____
18. DO YOU EVER FEEL SUDDEN WEAKNESS IN YOUR KNEES OR OTHER BODY PARTS WHEN LAUGHING, ANGRY, SAD, OR EMOTIONAL? _____
19. DO YOU EVER FIND YOURSELF SOMEWHERE AND NOT REMEMBER HOW YOU GOT THERE? _____

- 20. DO YOU SLEEP WALK? _____
- 21. DO YOU HAVE BAD NIGHTMARES? _____
- 22. DO YOU HAVE A BEDWETTING PROBLEM? _____
- 23. DO YOU TALK IN YOUR SLEEP? _____
- 24. DO YOU GRIND YOUR TEETH AT NIGHT? _____
- 25. DO YOU SLEEP WITH MORE THAN ONE PILLOW? _____

- 26. DO YOU URINATE MORE THAN ONCE AT NIGHT? _____
- 27. DOES PAIN DISTURB YOUR SLEEP? _____
- 28. DOES NOISE/LIGHT DISURB YOUR SLEEP? _____
- 29. DO YOU WAKE UP FEELING TIRED, DISORIENTED, OR FOGGY? _____
- 30. DO YOU FEEL EXTREMELY SLEEPY DURING THE DAY? _____
- 31. DO YOU TAKE NAPS ON PURPOSE DURING THE DAY? _____

THE FOLLOWING IS A SCALE TO ASSESS THE DEGREE OF YOUR DAYTIME SLEEPINESS. USE THE MOST APPROPRIATE NUMBER TO DESCRIBE HOW LIKELY YOU ARE TO DOZE OFF IN EACH SITUATION:

0 = WOULD NEVER DOZE; 1 = SLIGHT CHANCE OF DOZING;
2 = MODERATE CHANCE OF DOZING; 3 = HIGH CHANCE OF DOZING.

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
1. SITTING AND READING	_____
2. WATCHING T.V.	_____
3. SITTING, INACTIVE IN PUBLIC (E.G. AT A MEETING OR IN A THEATER)	_____
4. AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	_____
5. LYING DOWN TO REST IN THE AFTERNOON	_____
6. SITTING AND TALKING TO SOMEONE	_____
7. SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	_____
8. IN A CAR WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC (NON-DRIVERS SHOULD ANSWER WHEN THEY ARE ON A SUBWAY/BUS/TAXI)	_____
 TOTAL SCORE (PLEASE ADD UP NUMBERS)	 _____

PLEASE CIRCLE THE FOLLOWING MEDICAL CONDITIONS THAT APPLY TO YOU:

TROUBLE CONCENTRATING, FORGETFULNESS, TROUBLE SEEING OR HEARING, TROUBLE MOVING, TROUBLE FEELING, TROUBLE WITH BALANCE, HEADACHES, FAINTING, SEIZURES, CHEST PAINS, HEART RACING, NAUSEA, VOMITING, CONSTIPATION, DIARRHEA, BURNING WHEN URINATING, BLOOD IN URINE, JOINT PAIN, JOINT SWELLING, MUSCLE TWITCHING, SKIN RASH, WEIGHT LOSS, WEIGHT GAIN, DEPRESSION, ANXIETY, EMPHYZEMA, CHRONIC BRONCHITIS, ASTHMA, MUSCLE DISEASE, THYROID DISEASE, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE.

- HAVE YOU GAINED WEIGHT IN THE LAST 10 YEARS? IF YES, HOW MANY POUNDS? _____
- HAVE YOU HAD YOUR TONSILS REMOVED? IF YES, WHEN? _____
- HAVE YOU HAD MAJOR SURGERIES OR HOSPITALIZATIONS? _____

IF YES, WHEN AND WHAT KIND? _____

HAVE YOU HAD ANY SERIOUS INJURIES? _____

PLEASE PROVIDE DETAILS FOR ANY ILLNESSES YOU HAVE CIRCLED OR ANY THAT ARE NOT LISTED.

DO YOU HAVE ANY ALLERGIES? NO ___ YES ___ (PLEASE SPECIFY) _____

DO YOU TAKE MEDICATIONS? NO ___ YES ___ (PLEASE SPECIFY BELOW)

NAME	DOSAGE	REASON TAKEN FOR

DID TESTS (e.g. BLOOD WORK, X-RAYS) DONE AT ANOTHER PHYSICIAN'S OFFICE SHOW ANY ABNORMALITIES? NO ___ YES ___

IF YES, RESULTS: _____

DOES ANYONE IN YOUR FAMILY (BLOOD RELATIVES ONLY) HAVE A HISTORY OF THE SAME SLEEP PROBLEMS THAT YOU HAVE? _____

ARE YOU: ___ MARRIED ___ SINGLE ___ DIVORCED ___ SEPARATED

WHAT IS YOUR OCCUPATION? _____

WHERE DO YOU WORK? _____

DO YOU SLEEP: ___ WITH SOMEONE IN THE SAME BED ___ IN THE SAME ROOM ___ ALONE

DO YOU HAVE SEXUAL PROBLEMS? NO ___ YES ___

DO YOU USE DRUGS? ___ MARIJUANA ___ COCAINE ___ HEROINE ___ OTHER

WHAT DO YOU LIKE TO DO IN YOUR SPARE TIME (HOBBIES, CRAFTS, ORGANIZATIONS, SPORTS, ETC.)?

PLEASE LIST: _____

ARE YOU A SMOKER? NO ___ YES ___

WHAT IS THE **KIND OF** AND **TOTAL AMOUNT** OF ALCOHOL YOU DRINK IN AN AVERAGE 24-HOUR PERIOD?

HOW MANY CUPS/CANS OF THE FOLLOWING BEVERAGES CONTAINING CAFFEINE DO YOU DRINK IN AN AVERAGE 24-HOUR PERIOD? _____ COFFEE _____ TEA _____ COCA-COLA

PLEASE ADD ANY COMMENTS OR PROBLEMS NOT LISTED IN THIS QUESTIONNAIRE:

THANK YOU!

The following is for the physician's use only

BP: _____ HR: _____ RESP. RATE: _____ HEENT: _____ REFLEXES: _____

Imp:

Plan: