

SLEEP HISTORY QUESTIONNAIRE

Welcome to Guam Sleep Center! Your responses in this questionnaire will help our sleep specialist focus on your specific sleep problem. Thank you for your cooperation.

TODAY'S DATE: _____

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? NO YES

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

PLEASE COMMENT ON DIFFICULTIES YOUR SLEEP PROBLEM HAS CAUSED/AGGRAVATED AT HOME, WORK, OR WITH FAMILY?

HAVE YOU EVER HAD A SLEEP STUDY? NO YES IF YES, WHEN? _____ RESULTS: _____

BEFORE GOING TO BED DO YOU:

DRINK ALCOHOLIC BEVERAGES? NO YES IF YES, WHAT AND HOW MUCH? _____ *

DRINK CAFFINATED DRINKS? NO YES IF YES, PLEASE SPECIFY: COFFEE____ TEA____ SODA____

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

WEEKDAYS/WEEKNIGHTS

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?	

WEEKENDS

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?	

FREQUENCY	<p>Please circle the number of the question if your answer is “YES” . For those questions with a “YES” response, please indicate/estimate how often it occurs per week under “FREQUENCY” (e.g. "3" means it occurs up to 3 times per week.)</p>
	1. DO YOU HAVE TROUBLE GOING TO SLEEP?
	2. DO YOU WAKE UP DURING THE NIGHT? IF SO, 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 AWAKENING?
	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 ACT OUT YOUR DREAMS?
	24. DO YOU TALK IN YOUR SLEEP?
	25. DO YOU GRIND YOUR TEETH AT NIGHT?
	26. DO SLEEP WITH MORE THAN ONE PILLOW?
	27. DO YOU URINATE MORE THAN ONCE AT NIGHT?
	28. DOES PAIN DISTURB YOUR SLEEP?
	29. DOES NOISE/LIGHT DISURB YOUR SLEEP?
	30. DO YOU WAKE UP FEELING TIRED, DISORIENTED, OR FOGGY?
	31. DO YOU FEEL EXTREMELY SLEEPY DURING THE DAY?
	32. DO YOU TAKE NAPS ON PURPOSE DURING THE DAY?

The following is a scale to assess the degree of your daytime sleepiness. Please use the **one most appropriate number** to describe how likely you are to doze off in each situation:

0= WOULD NEVER DOZE **1**= SLIGHT CHANCE **2**= MODERATE CHANCE **3**= HIGH CHANCE

CHANCE OF DOZING	SITUATION
	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 MAY ANSWER AS IF THEY ARE PASSENGERS ON THE SUBWAY, BUS, TAXI, ETC.)
PLEASE TOTAL YOUR SCORE	

Please indicate which of the following medical conditions apply to you:

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

HAVE YOU GAINED WEIGHT IN THE LAST 10 YEARS? NO YES IF YES, HOW MANY POUNDS? _____

HAVE YOU HAD YOUR TONSILS REMOVED? NO YES IF YES, WHEN? (MM/DD/YYYY) _____

HAVE YOU HAD MAJOR SURGERIES OR HOSPITALIZATIONS? NO YES

IF YES, WHEN & WHAT KIND? _____

HAVE YOU HAD ANY SERIOUS INJURIES? NO YES

IF YES, WHEN & WHAT KIND? _____

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

DO YOU HAVE ANY ALLERGIES? NO YES IF YES, PLEASE SPECIFY: _____

DO YOU TAKE MEDICATIONS? NO YES IF YES, PLEASE LIST NAMES, DOSAGE, AND REASON:

NAME	DOSAGE	REASON TAKEN

DID TESTS (e.g. BLOOD WORK, X-RAYS) DONE AT ANOTHER CLINIC SHOW ANY ABNORMALITIES?

NO YES IF YES, RESULTS: _____

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

NO YES IF YES, PLEASE SPECIFY: _____

ARE YOU: MARRIED SINGLE DIVORCED SEPARATED WIDOWED

WHAT IS YOUR OCCUPATION? _____

WHERE DO YOU WORK? _____

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

DO YOU HAVE SEXUAL PROBLEMS? NO YES

DO YOU USE DRUGS? MARIJUANA COCAINE HEROINE OTHER NONE

DO YOU SMOKE CIGARETTES? NO YES IF YES, HOW MANY DO YOU SMOKE IN 1 DAY? _____

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

PLEASE LIST: _____

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

HOW MANY CUPS OR CANS OF THE FOLLOWING CAFFEINATED BEVERAGES DO YOU DRINK IN AN AVERAGE 24-HR PERIOD?

_____ COFFEE _____ TEA _____ SODA _____ OTHER (PLEASE SPECIFY)

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

Thank you for completing our questionnaire!

FOR PHYSICIAN'S USE ONLY

BP: _____ HR: _____ O2: _____ RESP. RATE: _____ HEENT: _____ REFLEXES: _____
Imp: _____ Plan: _____