Sleep History Questionnaire

Name: ____________________________ DOB: ___________ Age: ___________ Date: ___________

☐ Male  ☐ Female  Height: ___________ Weight: ___________ Marital Status: ☐ M  ☐ S  ☐ D  ☐ W

Recent Change in Weight?  ☐ Yes  ☐ No  Neck Circumference: ___________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Choose the number that most appropriately applies to each situation:

0 - Would Never Doze  1 - Slight Chance of Dozing  2 - Moderate Chance of Dozing  3 - High Chance of Dozing

Sitting and reading. ___________ Lying down to rest in the afternoon. ___________
Watching television. ___________ Sitting and talking to someone. ___________
Sitting inactively in a public place. ___________ Sitting quietly after lunch without alcohol. ___________
As a passenger in a car for about an hour. ___________ In a car while stopped for a few minutes. ___________

Total: ___________

On an average night:

How long does it take you to fall asleep? ___________
How many hours do you spend in bed? ___________
How many hours do you sleep at night? ___________
Number of awakenings: ___________
Length of awakenings: ___________

Do you feel refreshed in the morning?  ☐ Yes  ☐ No
Do you awaken with a headache?  ☐ Yes  ☐ No
What is your usual bedtime? ___________
What time do you get up in the morning? ___________

Do you or have you ever been told that you:

Grunt or grind your teeth at night?  ☐ Yes  ☐ No
Have night sweats?  ☐ Yes  ☐ No
Experience leg cramps or tingling?  ☐ Yes  ☐ No
Repeatedly kick your legs while asleep?  ☐ Yes  ☐ No
Awaken with a sour or bitter taste in your mouth?  ☐ Yes  ☐ No
Hold your breath while you sleep?  ☐ Yes  ☐ No
Awaken choking, gasping, or short of breath?  ☐ Yes  ☐ No
Fall asleep unintentionally?  ☐ Yes  ☐ No
Snore? Since when? ___________

Do you experience any of the following:

☐ Light Snoring  ☐ Snoring Interrupted by Silence / Gasping
☐ Moderate Snoring  ☐ Trouble Concentrating
☐ Loud Snoring  ☐ Falling Asleep at Inappropriate Times
☐ Choking  ☐ Short Temper
☐ Talking in Sleep  ☐ Lack of Energy
☐ Sleep Walking  ☐ Pain During the Night
☐ Restless Sleep  ☐ Fatigue

Do you ever:

☐ Read while in bed.
☐ Watch TV in bed. (or bed-partner does)
☐ Share your bed with anyone.
☐ Take naps.  How long? ___________

Are they refreshing?  ☐ Yes  ☐ No
☐ Awake to urinate during the night.

How often? ___________

Are you experiencing excessive daytime sleepiness?  ☐ Yes  ☐ No  How Long? ___________

Are you bothered by feelings of restlessness, or need to move your legs, or pace when sitting for long periods of time?

☐ Yes  ☐ No  During Awakenings?  ☐ Yes  ☐ No.  When trying to fall asleep?  ☐ Yes  ☐ No

Do you experience vivid dream-like episodes or feel paralyzed when waking or falling asleep?  ☐ Yes  ☐ No

Do you feel anxious, depressed or Irritable?  ☐ YES  ☐ NO  If yes, Please Explain: ___________

Please explain your sleep problem in detail:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________