

APPENDIX 3.4: SLEEP HISTORY QUESTIONNAIRE

Name _____

Age _____ Race/Ethnicity _____ Date _____

Name of Primary Physician: _____

Name of Referring Physician (*if not your primary physician*): _____

Briefly describe the problem(s) you are experiencing with your sleep or the reason you were referred to our sleep center. _____

When did you first notice your sleep problem? What may have contributed to the onset of your difficulty sleeping (i.e., birth of a child, death of a loved one, traumatic event)? _____

What do you feel are the major contributors to your sleep problem at this time? _____

What medications and other treatments have you tried for your sleep problem to date? _____

What medication(s) are you currently taking for sleep? And how many times per week? _____

How long (on average) does it take you to get to sleep? _____

How many times do you wake up in an average night? _____

How long on average do you remain awake during these awakenings (in total)? _____

How much sleep do you get in total in an average night? _____ hours/night

How much sleep do you feel you need each night to feel well rested and able to function? _____ hours/night

<i>Does a poor night's sleep make you</i>			<i>Does a poor night's sleep negatively affect your</i>		
	YES	NO		YES	NO
Depressed	☐	☐	Ability to concentrate	☐	☐
Anxious	☐	☐	Memory	☐	☐
Irritable	☐	☐	Ability to work	☐	☐
Fatigued	☐	☐	Mood	☐	☐

Other (please describe): _____

Sleep Symptoms:

	YES	NO
Has anyone told you that you snore loudly?	☐	☐
Has your family told you that you quit breathing at night?	☐	☐
Have you ever awakened gasping for breath?	☐	☐
Have you ever awakened at night with a sour taste in your mouth, or a burning sensation in your chest?	☐	☐
Do you have morning headaches?	☐	☐
Are you sleepy even when you increase your sleep time?	☐	☐
	YES	NO
Do you have trouble getting to sleep at night?	☐	☐
Do you have trouble staying asleep at night?	☐	☐
Do you have frequent awakenings and/or restless sleep?	☐	☐
	YES	NO
Do you frequently kick and jerk your legs at night while trying to fall asleep?	☐	☐
Do you have discomfort in your legs while trying to fall asleep?	☐	☐
If YES to previous question, does moving your legs give you relief of discomfort?	☐	☐
Do you have tingling or discomfort in your legs during the day?	☐	☐
Do you have discomfort in your legs when sitting for long periods?	☐	☐
	YES	NO
Do you have sudden episodes of sleep during the day?	☐	☐
Have you ever experienced periods in which you feel paralyzed while going to sleep, or waking up?	☐	☐

Have you ever had visual hallucinations or dream-like mental images when falling to sleep?	☐	☐
Have you ever experienced sudden physical weakness during strong emotions? (such as your mouth dropping open or legs going limp, during laughter or anger).	☐	☐
Were you excessively sleepy as a teenager or young adult?	☐	☐
	YES	NO
Do you sleep walk?	☐	☐
Do you talk in your sleep?	☐	☐
Do you have frequent nightmares?	☐	☐
Do you ever wake up screaming at night?	☐	☐
Do you eat in the middle of the night?	☐	☐
Do you physically act out your dreams at night?	☐	☐
	YES	NO
Do you grind your teeth in your sleep?	☐	☐
Have you or your dentist noticed your teeth being worn down?	☐	☐
Have you noticed that your teeth hurt?	☐	☐
Do you experience pain in your jaw muscles?	☐	☐
Has anyone told you that you make sounds with your teeth or jaw during sleep?	☐	☐
	YES	NO
Do you have rotating or night shift work?	☐	☐
Have you ever worked shift work or had an on-call schedule?	☐	☐
Do you have difficulty getting to sleep at your desired time?	☐	☐
Do you wake up in the morning prior to your desired time?	☐	☐
Do you find that your present sleep schedule is inconvenient, inappropriate, or unsatisfactory?	☐	☐

Sleep Schedule

	Weekday	Weekend
Time you go to bed	_____	_____
Time you get up	_____	_____
Average amount of sleep per night	_____	_____