

Center for Sleep Evaluation
SLEEP HISTORY FORM

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Did you first learn about the Center for Sleep Evaluation from your doctor? _____ Yes _____ No

If no, how did you hear about us? _____

Where did you first hear about sleep disorders? _____

My main sleep complaint involves (mark all types that apply and describe) :

_____ trouble sleeping at night _____ being sleepy all day _____ unwanted behaviors during sleep
(explain below)

Please describe your sleep problem(s): _____

My sleep/ wake problem began (date and details): _____

What have you done to treat your problem? _____

I hope the Sleep/ Wake Disorders Center Staff will help me by: _____

Sleep Evaluation Questionnaire

1	2	3	4	5	6	7
None or Never	Very Slight or Rarely	Slight or Seldom	Moderate or Occasional	Major or Often	Great or Very Often	Very Great or Always

How often do you fall asleep during the day, particularly when you are still or not busy?

How great of a problem do you have with non-restorative or restless sleep?
(that is no matter how much sleep you get, you don't wake up feeling rested)

How often do you drift off while driving?

Do you suffer from unexplained fatigue during the day?

Do you snore during sleep?

How often has a bed partner noted that you hold or stop breathing during sleep?

How often is your sleep disturbed by other breathing problems?

Do you suffer from headaches upon waking?

How often do you awaken because of heartburn or regurgitation?
(burning in the throat or gagging on stomach contents)

How often is your sleep disturbed because of chest pain or angina?

How often has a bed partner noted that your legs twitch or kick in your sleep?

How often are you troubled by restless or "creepy" leg in the evening or night?

How often do you feel unable to move (paralyzed) when just falling asleep or waking up?

How often do you have a dream like images (hallucinating people or sounds in the room)
when just falling asleep or awakening, even though you know that you are not asleep?

How often during the day do you have episodes of sudden muscular weakness when
laughing, angry, or in other emotional situations?

How often is your sleep disturbed by other problems?
(walking, nightmares, abnormal behaviors, etc.)

What time do you usually go to bed? _____ AM _____ PM

How long does it usually take you to fall asleep after deciding to go to sleep? _____ Hr _____ Min.

How many times do you wake up during a typical night? _____ times

What are the total hours of sleep that you usually get at night? _____ Hr _____ Min.
(do not include the time you spend awake in bed at night)

MEDICAL HISTORY

Height _____ Weight _____ pounds Last physical exam (year) _____

Do you currently smoke? Yes _____ No _____

If no, but you smoked in the past, how long has it been since you stopped? _____

For how many years did (have) you smoked? _____

How many cigarettes, cigars, pipefuls of tobacco do(did) you use daily (please circle type of usage) _____

List briefly the health problems you have had and their treatment:

<u>SYSTEM</u>	<u>PROBLEM/TREATMENT</u>	<u>DATE</u>	<u>TREATING PHYSICIAN CLINIC/HOSPITAL</u>
Respository conditions (asthma,COPD,etc.)	_____	_____	_____
Eyes, ears, nose, throat/mouth (glaucoma,sinus ,obstruction,allergies, surgery,etc)	_____	_____	_____
Heart,circulation, blood pressure	_____	_____	_____
Stomach, digestive, intestines	_____	_____	_____
Kidney, urological, or sexual disease	_____	_____	_____
Head/Nervous system (e.g., head trauma, convulsions) :	_____	_____	_____
Psychological/ Psychiatric	_____	_____	_____
Accidents, injurie,(e.g. bone fractures, dislocations)	_____	_____	_____
Surgical operations, (e.g. tonsillectomy, nasal surgery, hysterectomy, etc.)	_____	_____	_____
Other conditions (e.g., painful conditions, hormone abnorm., diabetes, thyroid, etc.)	_____	_____	_____

Family Health History: For each family member, write current age or age at death, present state of health (good, fair, poor) or cause of death, as well as sleep problems (snoring, insomnia, sleepiness, etc.) and major illnesses.

Relationship	If Living, Age/Health	If Deceased, Age/Cause	Sleep/ Medical Problems
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Spouse _____	_____	_____	_____
Brothers _____	_____	_____	_____
_____	_____	_____	_____
Sisters _____	_____	_____	_____
_____	_____	_____	_____
Children _____	_____	_____	_____
_____	_____	_____	_____

Nutrition Assessment

Special diet? Yes _____ No _____

If yes, please describe your diet: _____

Do you use any diet products? Yes _____ No _____

If yes, please describe: _____

How many meals do you eat each day? _____ How many snacks? _____

Do you exercise or play sports? Yes _____ No _____

If yes, how many days per week do you exercise? _____ How long do you usually exercise? _____

Please describe your exercise: _____

Do you want help in planning your diet or losing weight? Yes _____ No _____

In the last 12 months how many pounds have you (please circle appropriate term) gained or lost? _____

In the last four months how many pounds have you (circle appropriate term) gained or lost? _____

List the amounts of the following beverages you consume. If not used everyday, list in the far right column the average per week.

	Daily	After 6pm.	Weekly
Cups of coffee	_____	_____	_____
Decaffeinated coffee (cups)	_____	_____	_____
Tea (glass or cups)	_____	_____	_____
Carbonated drinks (cans/bottles)	_____	_____	_____
Beer, wine, liquor (cans/bottles)	_____	_____	_____
Recreational Drugs (list) _____	_____	_____	_____

Name and address of regular physician

Name and address of referring physician
(if not your regular physician)

Use the space below for additional comments that you may wish to make about your health, or intake of drugs, medicines or alcohol.

Name of bed partner _____

Date _____

I have observed this person's sleep:

_____ Never _____ Once or twice _____ Often _____ Almost every night

Check and of the following behaviors that you have observed this person doing while asleep. Circle those that you consider severe problems for this person.

- | | |
|--|-------------------------------------|
| _____ light snoring | _____ loud snoring |
| _____ loud snorts | _____ choking |
| _____ pause in breathing (how long? _____ seconds) | _____ gasping for air |
| _____ twitching or kicking of the legs | _____ twitching or flinging of arms |
| _____ sleep talking | _____ grinding teeth |
| _____ bed wetting | _____ sitting up in bed not awake |
| _____ awakening with pain | _____ head rocking or banging |
| _____ getting out of bed not awake | _____ biting tongue |
| _____ becoming very rigid and/or shaking | _____ crying out |
| _____ apparently sleeping even if he/she behaves otherwise | |
| _____ other (explain) _____ | |

If this person snores, what makes it worse?

_____ Sleeping on his/her back _____ Sleeping on his/her side _____ Alcohol _____ Fatigue

Does the snoring sometimes require you or your partner to sleep separately? _____ Yes _____ No

Describe the sleep behaviors checking in more detail. Describe the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? _____ Yes _____ No

If yes, please explain: _____

Does this person use sleeping pills? _____ Yes _____ No

If yes, how many pills per week?

_____ Less than 1 per week _____ 1-3 per week _____ 4-7 per week _____ 7+ per week

Do you consider this usage a problem? _____ Yes _____ No _____ Uncertain

Comments: _____

Does this person drink alcohol? _____ Yes _____ No

If yes, this person usually drinks: (check as many as you believe appropriate)

_____ Beer _____ Wine _____ Shots of liquor

Please estimate the per week use of:

_____ 12oz bottle/can/tap beer _____ 6-8oz glasses of wine _____ 1-1 ½ ox of liquor

Please estimate how much this person drinks in the three hours before bed _____

Do you consider this person's drinking a problem? _____ Yes _____ No _____ Uncertain

Comments: _____

If this person uses street drugs, please describe both types and frequency of usage: _____

Do you believe that this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/ drug usage?

_____ Yes _____ No _____ Uncertain

Comments: _____

Thank you.

Signed _____ Relationship to bed partner: _____

Name: _____

The Epworth Sleepiness Scale

How likely are you to dose 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 work out how they would have affected you. Use the following scale to choose the **most appropriate** number for each situation.

- 0= Would never doze
- 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 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 lunch without alcohol

In a car, while stopped for a few minutes in traffic

Thank you for your cooperation