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. ________

Watching television. ________

Sitting inactively in a public place. ________

As a passenger in a car for about an hour. ________

Lying down to rest in the afternoon. ________

Sitting and talking to someone. ________

Sitting quietly after lunch without alcohol. ________

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:

Grit 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? ______________ ☐ Yes ☐ No

Do you experience any of the following:

☐ Light Snoring

☐ Moderate Snoring

☐ Loud Snoring

☐ Choking

☐ Talking in Sleep

☐ Sleep Walking

☐ Restless Sleep

☐ Snoring Interrupted by Silence / Gasping

☐ Trouble Concentrating

☐ Falling Asleep at Inappropriate Times

☐ Short Temper

☐ Lack of Energy

☐ Pain During the Night

☐ 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: ______________________

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Please explain your sleep problem in detail: ______________________________

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