Whitney Sleep
Diagnostics & Consultants

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Sleep History Questionnaire

Date:	Patient Name:		DOB:
Referring Physician:		Primary Physician:	
If no Referring Physician, how did you hear about us:			
Preferred Language:	Ethnicity:	Race:	
Height:	Present Weight:	Weight 1 year ago:	Weight High School:

Yes No

☐ ☐ Have you been told you snore?
☐ ☐ Are you excessively tired during the day?
☐ ☐ Have you been told you stop breathing during sleep?
☐ ☐ Do you have a history of hypertension?
Blood pressure: _____/_____
Heart rate: _____
☐ ☐ Is your neck size greater than 17 inches (male) or greater than 16 inches (female)?
Indicate Neck circumference: _____inches
☐ ☐ Do you wake up to use the bathroom more than twice a night?
☐ ☐ Do you have aching or restlessness in your legs at night with an urge to move them?
☐ ☐ Do you awake in the morning feeling refreshed?
☐ ☐ Any history of accidents (work or car) due to sleepiness? Describe: _____
☐ ☐ Do you currently use a sleep aid? Name of medication: _____

Epworth Sleepiness Scale

Please rate on a scale of 0-3 how likely you are to doze off in each of the following situations.
0 = would NEVER doze 1 = SLIGHT chance of dozing 2 = MODERATE chance of dozing 3 = HIGH chance of dozing

0 1 2 3 Sitting and reading
0 1 2 3 Watching TV
0 1 2 3 Sitting, inactive, in a public place
0 1 2 3 As a passenger in a car for an hour without a break
0 1 2 3 Lying down to rest in the afternoon when circumstances permit
0 1 2 3 Sitting and talking to someone
0 1 2 3 Sitting quietly after lunch
0 1 2 3 In a car, while stopped for a few minutes in traffic
_____ TOTAL

Yes	No	
☐	☐	Do you suffer from nasal allergies?
☐	☐	Have you had corrective nasal surgery?
☐	☐	Do you take any medications that cause you to suffer from dry mouth?
☐	☐	Do you sleep in a cool room? (less than 65 degrees)
☐	☐	Do you sleep with the windows open year round?
☐	☐	Do you feel like you have chronic nasal congestion issues?
☐	☐	Are you over the age of 60?

Pharmacy: _____

☐ YES ☐NO Can we contact your pharmacy to receive an electronic updated copy of your medication list?

EMERGENCY CONTACT: ***someone not in patient household***

NAME:	RELATIONSHIP:
PHONE:	ALT PHONE:

CURRENT MEDICATIONS	DOSAGE AND FREQUENCY

Medication Allergy	Reaction

CHIEF COMPLAINT - ANSWER ALL THAT APPLY	Duration (years/months)
Excessively tired throughout the day	
Gasping for air during the night	
Snoring	
Can't fall asleep at night	
Can't stay asleep at night	

Unusual behaviors during sleep ☐ YES ☐NO Explain: _____

SLEEP PATTERNS/ENVIRONMENT	Weekdays	Weekends
Typical bedtime		
Amount of time to fall asleep		
Time up in the morning		
Average number of hours slept		
Average number of awakenings per night		
Number of bathroom trips		
Number of naps		

SLEEP DISTURBANCES - CHECK ALL THAT APPLY

☐Pain ☐Snoring ☐Spouse ☐ Breathing ☐ Worrying
☐Anxiety ☐Pets ☐Children ☐ Coughing
Other:_____

PAST SLEEP EVALUATION AND TREATMENT (IF APPLICABLE)

Last sleep evaluation:
☐Less than 6 months ago ☐Less than 1 year ago ☐ _____ years ago

Where_____
It included: ☐Overnight Sleep Study ☐Daytime Naps

Diagnosis:_____

☐ YES ☐NO I use a CPAP or Bi-Level Machine
Pressure setting: _____cm/H2O
Mask type/brand: _____

☐ YES ☐NO I have had surgery to treat a sleep disorder
Type of surgery: _____

☐ YES ☐NO I have been prescribed medication to treat a sleep disorder
Medication:_____

PAST MEDICAL/SURGICAL HISTORY - CHECK ALL THAT APPLY

☐High Blood Pressure ☐Stroke ☐Depression ☐Anxiety ☐Asthma/Emphysema
☐Reflux ☐Seizures ☐Heart Disease ☐Cancer ☐Parkinson's Disease
☐Fibromyalgia ☐Lung conditions ☐ Thyroid Conditions ☐Head Injury ☐Hearing Impairment
☐Diabetes **(*note: diabetics should bring a snack to overnight sleep study appointment)***
☐**History of MRSA** (methicillin resistant staph aureus)
Have you been told recently or in the past that you have MRSA, VRSA or ESBL? ☐ No ☐ Yes

List any other medical problems that may disrupt your sleep

List any surgeries and the year performed

Do you use supplemental oxygen? ☐ YES ☐NO Amount:_____ LPM
Do you need assistance at night? ☐ YES ☐NO
Do you use a wheelchair? ☐ YES ☐NO

Approximate date of last influenza vaccine: _____

If age 65 or older, approximate date of last pneumococcal vaccine: _____

SOCIAL HISTORY

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Sleeping Arrangements: ☐ Sleep alone Share bed ☐Separate Beds

Occupation _____ ☐Employed ☐ Unemployed ☐Retired ☐Student

Smoking History:
☐ Never a smoker
☐ Current Smoker
Cigarettes/Cigars/Tobacco _____ packs/day for _____years
☐Former Smoker
Year quit _____ Packs/day_____ for _____ years

Alcohol Use:
☐Never ☐Daily ☐Weekends ☐Occasionally

Type of alcohol and amount: _____

Number of nights per week alcohol is used before bed_____

Caffeine use ☐Never ☐Daily ☐Weekends ☐Occasionally
Type of caffeine beverage and amount per day: _____

FAMILY HISTORY - CIRCLE ALL THAT APPLY

Mother	apnea	snoring	narcolepsy	insomnia	other:_____
Father	apnea	snoring	narcolepsy	insomnia	other:_____
Sister(s)	apnea	snoring	narcolepsy	insomnia	other:_____
Brother(s)	apnea	snoring	narcolepsy	insomnia	other:_____

Other_____

I have trouble falling asleep.	Never	Sometimes	Always	Unsure
I have trouble staying asleep.	Never	Sometimes	Always	Unsure
I read or watch TV in bed before falling asleep.	Never	Sometimes	Always	Unsure
I often wake up during the night.	Never	Sometimes	Always	Unsure
At bedtime, thoughts race through my mind.	Never	Sometimes	Always	Unsure
I smoke less than 2 hours before going to bed.	Never	Sometimes	Always	Unsure
I eat a snack at bedtime.	Never	Sometimes	Always	Unsure
If I wake up at night I eat a snack.	Never	Sometimes	Always	Unsure
I have nightmares.	Never	Sometimes	Always	Unsure
I sweat a lot during the night.	Never	Sometimes	Always	Unsure
I kick my legs and/or arms during the night.	Never	Sometimes	Always	Unsure
I walk in my sleep.	Never	Sometimes	Always	Unsure
I talk in my sleep.	Never	Sometimes	Always	Unsure
I grind my teeth while I sleep.	Never	Sometimes	Always	Unsure
I wake up at night choking or gasping for air.	Never	Sometimes	Always	Unsure
I wake myself up with my snoring.	Never	Sometimes	Always	Unsure
I have been told I snore while lying on my back.	Never	Sometimes	Always	Unsure
I feel my heart pounding at night.	Never	Sometimes	Always	Unsure
At bedtime I feel sad or depressed.	Never	Sometimes	Always	Unsure
I feel unable to move (paralyzed) after a nap.	Never	Sometimes	Always	Unsure
I have dream like images when I wake up even though I know I am not asleep.	Never	Sometimes	Always	Unsure
I have experienced sudden muscle weakness in response to emotions such as laughter or surprise.	Never	Sometimes	Always	Unsure
I take a nap(s) on a regular basis.	Never	Sometimes	Always	Unsure
I have fallen asleep while driving.	Never	Sometimes	Always	Unsure
I get “stuffed up” while sleeping.	Never	Sometimes	Always	Unsure
My breathing is worse when I sleep on my back.	Never	Sometimes	Always	Unsure
I get morning headaches.	Never	Sometimes	Always	Unsure
I wake up with a dry mouth.	Never	Sometimes	Always	Unsure
Pain wakes me up at night.	Never	Sometimes	Always	Unsure
I wet the bed.	Never	Sometimes	Always	Unsure
I wake up due to heartburn,reflux,a sour stomach,or burping.	Never	Sometimes	Always	Unsure