

# Sleep History and Questionnaire



## Patient Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

## Sleep Problems Please check all that apply

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep       | <input type="checkbox"/> Walk or talk in your sleep              |
| <input type="checkbox"/> Difficulty maintaining sleep    | <input type="checkbox"/> Legs that ache or move a lot at night   |
| <input type="checkbox"/> Snoring                         | <input type="checkbox"/> Unknowingly strike at my bed-partner    |
| <input type="checkbox"/> Stop breathing at night (apnea) | <input type="checkbox"/> Heartburn that keeps me awake           |
| <input type="checkbox"/> Bad dreams or nightmares        | <input type="checkbox"/> Feel sleepy during the day              |
| <input type="checkbox"/> Nasal obstruction at night      | <input type="checkbox"/> Fall asleep unexpectedly during the day |

Please describe any other sleep symptoms or problems:

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Have you ever consulted a medical professional for this problem?  Yes  No

What treatment did you receive for this problem?

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## Sleep Environment Please estimate the number of times per week any of these items occur.

- x\_\_\_\_\_ I can see light in my bedroom during my sleep time, e.g. from windows, electronic devices or lights.
- x\_\_\_\_\_ Pets in the bedroom.
- x\_\_\_\_\_ Excessive heat or cold causing me to awaken.
- x\_\_\_\_\_ Noise that awakens me, e.g. road noise, noisy neighbors, bedroom or other noises in the home.
- x\_\_\_\_\_ Bed partner's snoring, movement or schedule awakens me.
- x\_\_\_\_\_ Uncomfortable bed that causes me to awaken.
- x\_\_\_\_\_ Pain that prevents me from falling asleep or awakens me at night.
- x\_\_\_\_\_ Frequent bathroom visits during the night. Number of times per *night*. x\_\_\_\_\_

## Sleep Hygiene Please check all that apply

- |  |  |
|--|--|
| <input type="checkbox"/> I watch TV in the bedroom                         | <input type="checkbox"/> I watch TV until bedtime            |
| <input type="checkbox"/> I work on my computer in the bedroom              | <input type="checkbox"/> I work on my computer until bedtime |
| <input type="checkbox"/> I do house work until bedtime                     | <input type="checkbox"/> I do work for my job until bedtime  |
| <input type="checkbox"/> I exercise within 3 hours of bedtime              | <input type="checkbox"/> My mind races when I go to bed      |
| <input type="checkbox"/> I am on call at night (either for family or work) | <input type="checkbox"/> I read novels until bedtime         |

## Sleep Schedule Please fill out the sleep diary on page 3

How many hours sleep do you usually get per night? \_\_\_\_\_

Work shift:  Day  Swing  Graveyard  Rotating  Split  Other

What are your work hours? \_\_\_\_\_

What is your usual bedtime? \_\_\_\_\_

Do you nap during the day?  Yes  No

How long do you nap? \_\_\_\_\_

What time is your usual nap time? \_\_\_\_\_

**Dietary Factors affecting your sleep**

I drink \_\_\_\_\_ ounces of caffeinated coffee before 10:00 AM. After 10:00 AM \_\_\_\_\_

I drink \_\_\_\_\_ ounces of caffeinated cola before 10:00 AM. After 10:00 AM \_\_\_\_\_

I drink \_\_\_\_\_ ounces of caffeinated tea before 10:00 AM. After 10:00 AM \_\_\_\_\_

I smoke \_\_\_\_\_ packs of cigarettes daily.

I drink \_\_\_\_\_ ounces of beer or \_\_\_\_\_ ounces of wine or \_\_\_\_\_ ounces of alcohol daily.

I use street drugs or medications for any purpose  No  Yes, please list: \_\_\_\_\_

I have used the following medications to improve my sleep. \_\_\_\_\_

**My Sleep Score Please check all words that express how you feel about yourself.**

How likely are you to “doze off” or fall asleep in the situations described below?

Use the following scale to select the number that is most appropriate for you.

Write your number in the space next to each situation on next page.

Total and record your score in the appropriate space

0 = Never    1 = Rarely    2 = Occasionally    3 = Regularly

\_\_\_\_\_ Sitting and reading

\_\_\_\_\_ Watching television

\_\_\_\_\_ Sitting inactive in a public place like a meeting or classroom

\_\_\_\_\_ As a passenger in a car for one hour

\_\_\_\_\_ Lying down to rest in the afternoon

\_\_\_\_\_ Sitting quietly after lunch (without alcohol)

\_\_\_\_\_ In a car while stopped for a few minutes in traffic

**Total Score**

Score results:

1-6 Good, you appear to be getting sufficient sleep.

7-8 Average, but more or better sleep may be needed.

9-24 Excessively sleepy, an evaluation by a sleep specialist is recommended.

**Sleep Hygiene Please check all that apply**

I watch TV in the bedroom

I work on my computer in the bedroom

I do house work until bedtime

I exercise within 3 hours of bedtime

I am on call at night (either for family or work)

I watch TV until bedtime

I work on my computer until bedtime

I do work for my job until bedtime

My mind races when I go to bed

I read novels until bedtime

## Sleep Diary

Patient Name: \_\_\_\_\_

**Instructions:** When filling out this sleep diary, estimate, to the best of your ability, the answers to the questions about your sleep for the night before. For example: if you begin this diary on Monday, on Tuesday morning estimate the answers for Monday and Monday night and record them in the column labeled "Day 1". Use the example column to help you format your answers.

	Example	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Prior to going to bed I napped from ____ to _____. (Note times of all naps)	<i>1:30 to 2:30 pm</i>							
I took ____ mg of medication and/or ____ oz. of alcohol before bed to help me sleep.	<i>Ambien 10 mg</i>							
I went to bed and turned the light off at ____ o'clock.	<i>11:15 pm</i>							
After turning the lights off, I fell asleep in ____ minutes	<i>35 min.</i>							
My sleep was interrupted ____ times during the night. Specify the number of awakenings.	<i>3</i>							
My sleep was interrupted for ____ minutes with each of the interruptions noted above	<i>10, 5, 20</i>							
This morning I awakened at ____ o'clock (Time of last awakening)	<i>6:15 am</i>							
This morning I got out of bed at ____ o'clock	<i>6:40 am</i>							
When I got up this morning I felt ____ 1 = exhausted to 5 = very refreshed	<i>2</i>							
Overall, my sleep last night was ____ 1 = very restless to 5 = very sound and restful	<i>3</i>							