Sleep History and Questionnaire

OLYMPIC MEDICAL PHYSICIANS

Patient Information

Todays Date:_____

Name:_____ Date of Birth:_____

Occupation:_____

Sleep Problems **Please check all that apply**

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

Please describe any other sleep symptoms or problems:

_____

_____

_____

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

What treatment did you receive for this problem?

_____

Sleep Environment **Please estimate the number of times per <u>week</u> 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**

- ❑ 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 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**

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