Bartlett Sleep Sciences

Sleep Disorders Laboratory

Patient History & Sleep Questionnaire

Patient Full Name: ____ Nick Name: ______________________________

Birth date:_____________________ Age:______ Sex: _________

Height:_________ Current Weight:_________ Weight Five Years Ago:_________ Peak Lifetime Weight:________

Marital Status: Single Married Divorced Widowed Separated

Employer: ____ Occupation: ____________________________________

PATIENT PROBLEM:

Briefly describe the problem with your sleep as you see it:

PATIENT EXPECTATION:

What is the nature of assistance you expect or desire?

Patient History

Yes No Have you been evaluated at a Sleep Disorders Center Before?

If yes, when (date) ___________ where____

What were you told the problem was? ____

What treatment were you given? ____

Why are you being evaluated again? ____

____

Yes No Do you have your last meal of the day within two hours of bedtime?

Yes No Do you have a problem with heartburn (gerd) on a regular basis?

Tobacco

Yes No Have you ever smoked tobacco?

Yes No Do you currently smoke tobacco? How much per day? ______ How long have you smoked?_________

Yes No If you smoke tobacco, do you smoke when you wakeup during the night?

Yes No If you smoke tobacco, have you noticed that nicotine alters or interferes with your sleep?

Beverages

Yes No Do you usually drink coffee, tea, chocolate, cola or other caffeinated beverages within 2 hours of your bedtime?

How much of the following do you have in a usual day?

Coffee/Tea______ Cola_______ Chocolate_______ Other_______

Yes No Do you drink alcoholic beverages?

Assuming the following drinks are equivalent: 12oz beer, 5oz wine, 3oz port, and 1.5oz whiskey, gin or vodka, then:

How many drinks do you have in a usual weekday? _________ On a weekend or holiday? _________

Yes No Do you drink alcohol within two hours of bedtime?

Yes No Do alcoholic beverages alter or interfere with your sleep?

Yes No Have you ever used alcohol in order to get to sleep?

Yes No Have you ever sought treatment/counseling for an alcohol problem?

Have you ever had the following problems in association with drinking alcoholic beverages?

Yes No Blackouts
Yes No Violent or over excited behavior
Yes No Automatic behavior (carrying on unaware of your actions)
Yes No D.T.'s, shakes, hallucinations
Yes No Arrests for drunken driving
Yes No Family complaints about your drinking
Yes No Personal concern about your drinking
Yes No Late or missed work or appointments
Yes No Detoxification or other treatment

Exercise

Yes No Do you exercise on a regular basis? If yes, how many times per week? ___________

What time of day do you usually exercise?_____________

General

Yes No Do you have Diabetes? If yes, what type?__________

Yes No Have you recently had any unexplained weight loss?

Yes No Have you noticed being unusually thirsty?

Yes No Have you noticed a need to urinate more frequently than usual?

Yes No Do you have high blood pressure?

Yes No Do you have congestive heart failure or other heart conditions?

Yes No Have you ever had heart surgery?

Yes No Have you had your tonsils removed?

Yes No Have you ever had nasal or throat surgery of any kind?

Yes No Have you ever had a nasal or throat injury that did not require surgery?

Yes No Do you have allergies to medications, animals, pollens or food? If yes, list below:

Allergy	Year of Onset

Medication

*Please list **all medications (prescription or over-the-counter)**, sedatives, herbs, vitamins or alternative medicines you are currently taking. Use a separate sheet if necessary.*

Medication	Dosage

Yes No Are any of the above medications to help you sleep?

Sleep Questionnaire

Sleep Hygiene

		How many hours of sleep do you get in a typical night? _________
Yes	No	Do you go to bed at the same time each night?
		If yes, what is your bedtime? _______
Yes	No	Do you get up the same time each morning?
		If yes, what is your rise time? ________
Yes	No	Do you feel like you get enough sleep at night?
Yes	No	Does your sleep schedule change by more than 2 hours on the weekends?
Yes	No	Do you read or watch TV in bed?
Yes	No	Are you a shift worker?
		If yes what is your usual shift and schedule: ____

Sleep Environment

Yes	No	Do you have a quiet, peaceful place to sleep?
Yes	No	Is your sleep disturbed because of noise, heat, cold, lights or pets?
		If yes, what are the disturbances? ____
Yes	No	Do you have any children under two living with you?

Excessive Daytime Sleepiness

Yes	No	Do you snore?
Yes	No	Do you or your bed partner believe that you move your arms or legs to much when you sleep?
Yes	No	Do you take naps during the day?
Yes	No	Do you wake up in the morning with a dry mouth?
Yes	No	Do you wake up in the morning with a headache?
Yes	No	Do you have many night sweats?
Yes	No	Has a bed partner ever witnessed you stopping breathing when you sleep?
Yes	No	Have you ever had a traffic accident due to drowsy driving?
Yes	No	Has a bed partner ever heard you gasping at night when you sleep?
Yes	No	Do you find it almost impossible to remain awake in a lecture, at your desk or in a meeting?
Yes	No	Do you wake up at night with your heart racing or in a panic?
Yes	No	Do you feel that your personality has changed due to sleepiness?

Insomnia

Yes No Do you have a hard time falling asleep?

How long does it take you to fall asleep usually? ____________

Yes No Do you fall asleep, but then wake up for no reason and can't fall back to sleep?

Yes No Do you feel that there are significant stresses in your life right now?

Yes No Are you afraid of going to sleep?

Yes No Do you watch TV, read or do paperwork in bed?

Yes No If you are unable to sleep, do you get out of bed?

If yes, what do you do? ____

Yes No Is it easier to fall asleep in another room or on the sofa or easy chair?

Limb Movements

Yes No Do your legs have a twitching, tingling or burning sensation when you are trying to go to sleep?

Yes No If yes, do you get up and walk around to relieve these symptoms?

Yes No Does your bed partner complain about you kicking your legs or arms at night?

Yes No Are you bothered by leg cramps or pains in the calf (charley horses) during the night?

Yes No Do you have any other type of pain during the day or night?

If yes, briefly explain: ____

Neurology

Yes No Do you have vivid dreams shortly after falling asleep at night?

Yes No Do you have hallucinations or dream-like mental images when you are falling asleep or as you wake up?

Yes No Have you ever felt paralyzed or unable to move when falling asleep at night?

Yes No Have you ever felt paralyzed or unable to move when waking in the morning?

Yes No Have you ever had attacks of sudden physical weakness or paralysis during the day, when laughing, angry or in other emotional situations?

If yes, how often does this happen? ________________

Yes No Do you ever have unexplained sleep episodes?

Yes No Are your dreams so vivid that sometimes you confuse them with reality?

Yes No Have you ever had a head injury?

If yes, explain: ____

Yes No Have you ever been told that you bang your head or make rolling or rocking movements in bed at night?

Yes No Have you been told you grind your teeth or do you know you do?

Dreaming & Sleep

Yes No Do you move while dreaming; as if attempting to carry out the dream?

Yes No Have you accidentally hurt yourself or bed partner during sleep, from arm flailing, leg jerking, falling out of bed or running into furniture?

Yes No Do you wake up from a dream in unusual places or doing unusual tasks?

If yes, please describe: ____

Epworth Sleep Scale

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

Using the following scale, select the number that is most appropriate for you.

0 - I would never dose off.
1 - There is a slight chance I would doze.
2 - There is a moderate chance I would doze.
3 - There is a high chance I would doze.

Write the number in the space after each situation:

Situations:

Sitting and reading_______

Watching television_________

Sitting inactive in a public place like a meeting or a classroom________

As a passenger in a car for one hour________

Lying down to rest in the afternoon__________

Sitting and speaking to someone__________

Sitting quietly after lunch (without alcohol)__________

In a car while stopped for a few minutes in traffic___________

Spouse or Roommate Questionnaire

Check any of the following behaviors that you have observed the patient doing.

While Asleep

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Sleep talking
- ❑ Sleep walking
- ❑ Bed wetting
- ❑ Sitting up in bed not awake
- ❑ Kicking of the legs
- ❑ Getting out of bed not awake

While Awake

- ❑ Depression
- ❑ Change in personality
- ❑ Loss of intellectual function
- ❑ Excessive daytime sleepiness
- ❑ Weight gain
- ❑ Grinding teeth
- ❑ Fatigue
- ❑ Morning headache
- ❑ Irritability

How long have you been aware of the sleep behaviors that you checked above?

Describe the sleep behaviors described above in more detail. Including the type of activity, the time of night in which it occurs, frequency during the night and whether it occurs every night.

If you have described loud snoring, do you remember hearing short pauses in the snoring or occasional loud snorts?