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Adult Sleep History Questionnaire

Please fill in the appropriate information below:

Name SSN Date

Birthdate Age

Physician(s)

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Race:

- ☐ African-American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other

Vital Statistics:

Height ____________
Neck Size ____________
Current Weight ____________
Weight 1 yr ago ____________
Weight 5 yrs ago ____________
Weight 10 yrs ago ____________
Weight 20 yrs ago ____________
(if over age 38)

Medications:

Please list anything you are taking including herbs, over-the-counter medications, vitamins, minerals, etc (Examples: Tylenol P.M., melatonin, teas).
Please include dose and time of day.

What are your goals related to your sleep problems?

Sleep Times:	**Week Days**	**Weekends**
What time do you go to bed?		
How long does it take you to fall asleep?		
What time do you wake up?		
What time do you get out of bed?		
No. of times per night you wake up?		
No. of naps per day		
Duration of naps		
No. of naps per week		

Sleep History Questionnaire (cont.)

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your current lifestyle. Even if you have not done some of these things recently, try to work out how they *would have affected you*. Use the following scale to choose the *most appropriate number* for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting, inactive in a public place (i.e., a theater or meeting)	______________
Sitting and reading	______________
Watching TV	______________
As a passenger in a car for an hour without a break	______________
Lying down to rest in the afternoon when circumstances permit	______________
Sitting and talking to someone	______________
Sitting quietly after lunch without alcohol	______________
In a car, while stopped for a few minutes in traffic	______________
TOTAL	________

What is the overall quality of your sleep on the scale below? (Circle)

Bad								**Excellent**	
1	2	3	4	5	6	7	8	9	10

Sleep History Questionnaire (cont.)

	YES	NO
On average do you feel you get enough sleep?	☐	☐
How many hours per night would you like to sleep? ________		
Have you ever been diagnosed with a sleep disorder? (Example: sleep apnea, narcolepsy, restless legs, insomnia, etc.)	☐	☐
Do you have problems with sleep?	☐	☐
If yes, for how long? ______________		
Have you ever had a sleep study? If yes, when? ______________ Where? ______________ Diagnosis Made ______________ Treatment ______________	☐	☐
Have you ever been treated for a sleep disorder?	☐	☐
Do you have any family members with sleep disorders? If yes, please explain. ______________________	☐	☐

	YES	NO
Have you ever had insomnia?	☐	☐
Were there any stressful events related to the beginning of your sleep difficulty?	☐	☐
Do you have trouble falling asleep?	☐	☐
Do you have trouble staying asleep?	☐	☐

How many nights per month do you have problems falling asleep?

☐ 0-1night ☐ 2-3 nights ☐ 4-5 nights ☐ >6

	YES	NO
When you wake up in the night, how long do you stay awake? ______________		
Do you wake up early in the morning unable to go back to sleep?	☐	☐
Do you worry about not being able to go to sleep?	☐	☐
Do you look forward to going to sleep?	☐	☐
Do you feel apprehension, anxiety or dread when you are getting ready to go to sleep?	☐	☐
Do you have racing thoughts that prevent you from sleeping?	☐	☐
Do you look at the clock to check the time when you cannot sleep?	☐	☐
On a typical night, how many times do you wake up? ______________		
Is your sleep disturbed by your bed partner or sleeping environment?	☐	☐

	YES	NO
Do you have problems staying awake or alert during the day or do you have sleep attacks?	☐	☐
Have you ever fallen down when angry or laughing?	☐	☐
If you nap, are your naps refreshing?	☐	☐
Do you ever awaken from sleep unable to move?	☐	☐
Do you see, hear or feel things or experience vivid hallucinations when falling to sleep or awaken from sleep?	☐	☐

	YES	NO
Do you drive?	☐	☐
Have you ever fallen asleep while driving?	☐	☐
Have you ever had a driving accident because you fell asleep?	☐	☐
Have you ever injured yourself at work because you fell asleep?	☐	☐

Ho do you feel when you wake up?

Rested ☐ Partially rested ☐
Not Rested ☐ Varies ☐

	YES	NO
Do you have trouble waking up from sleep?	☐	☐
Do you wake up with headaches?	☐	☐
Do you ever wake up with a dry mouth or throat irritation?	☐	☐
Have you been told you snore?	☐	☐
Do you experience night sweats?	☐	☐
Do you wake up to urinate at night?	☐	☐
Has anyone ever seen you stop breathing at night? If yes, how often? ______________	☐	☐
Do you ever wake up short of breath, choking, gasping for breath, with air hunger or chest tightness?	☐	☐
Are you having difficulty with memory?	☐	☐

	YES	NO
Do spontaneous leg jerks prevent you from falling asleep?	☐	☐
Do you have leg jerks that are partially or completely relieved with leg movement?	☐	☐
Do you grind your teeth at night?	☐	☐
Do you wake up with a sore tongue or jaws?	☐	☐
Do you walk in your sleep? If yes, how often? ______________	☐	☐
Do you occasionally wet the bed when sleeping?	☐	☐

Sleep History Questionnaire (cont.)

	YES	NO
Do you dream?	☐	☐
Do you awaken from sleep either screaming or violent?	☐	☐
Do you physically act out your dreams while asleep?	☐	☐
Do you have seizures during sleep?	☐	☐
Do you have or have you had seizures or epilepsy?	☐	☐

	YES	NO
Do you have heartburn or belching?	☐	☐
Have you ever had a tonsillectomy or any other throat surgery? If yes, what kind? ________	☐	☐
Have you ever had any thyroid problems or taken thyroid medicine?	☐	☐
Do you have any upper airway or lung conditions (i.e. hay fever, allergies, asthma, bronchitis, emphysema) that cause you to cough at night?	☐	☐
Do you have high blood pressure? If yes, for how long? ________	☐	☐
Do you have or have you ever had any heart problems?	☐	☐
Have you ever had a stroke? If yes, when? ________	☐	☐
Are you currently under the care of a psychologist or psychiatrist?	☐	☐

Do you have or have you had
Depression ☐ Panic Disorder ☐
Anxiety ☐ Mental illness ☐

	YES	NO
Do you often feel irritable, worried, nervous or anxious?	☐	☐
Have you ever had a significant head injury?	☐	☐
Do you have any conditions that cause you to experience nighttime or chronic pain?	☐	☐

	YES	NO
Do you smoke? If yes, how much ____ Packs/day ____ No. years	☐	☐
Do you smoke at night?	☐	☐

Do you drink alcohol?
If yes, how much? ____ How often? ____

	YES	NO
Do you drink caffeinate beverages? (i.e. coffee, tea, Coke, Pepsi) If yes, how much per day? ____	☐	☐
Have you ever had or do you currently have a substance abuse problem?	☐	☐
Do you exercise regularly? If yes, what time? ________	☐	☐
Is your bedroom dark, quiet and comfortable?	☐	☐
Is your bedroom frequently used for non-sleep related activities (i.e. watching TV, reading, studying, child care, eating, concentrated and arousing mental activities)?	☐	☐

What time do you leave to go to work? ____

	YES	NO
Do you drive to and from work?	☐	☐

What is your occupation? ________

How many days per week do you work? ____

	YES	NO
Do you work swing shift or night shift? If yes, for how long? ____ What are your working hours? ____	☐	☐
Have you ever fallen asleep at work?	☐	☐

Women Only

What was the date of your last menstrual period?
____

	YES	NO
Have you experienced menopause? If yes, when? ________	☐	☐
Have you had a complete hysterectomy? If yes, when? ________	☐	☐
Are you taking any estrogen, birth control pills or female hormones?	☐	☐
Are you pregnant?	☐	☐

Men Only

	YES	NO
Have you ever had a prostate problem?	☐	☐
Do you awaken at night to urinate? If yes, how often? ____	☐	☐
Has there been a change in your interest, drive or desire to have sexual intercourse?	☐	☐
Do you have problems having or keeping a penile erection?	☐	☐

What are your medical conditions?
____
____
____