

Sleep History Questionnaire

Date: _____

Patient Information:

Name: _____

Age: _____

Home Phone: _____

Date of Birth: _____

Height: _____

Weight: _____

In Case Of Emergency Contact: _____

Phone: _____

Primary Care Physician: _____

Phone: _____

Referring Physician (if different): _____

Phone: _____

Do You Require Handicapped Accommodations? YES NO If Yes, Please explain: _____

1. In the space below, please describe your main sleep problem(s) in your words. Include when and how this began, and what treatment you have received in the past for this problem.

2. How often does this sleep problem occur? (Check all that apply)

- Practically every night
 Irregularly

- At least once a week
 Other: _____

3. How long has this problem been present?

- This month
 One Year

- Several months
 Longer than Two Years

4. Which of the following best describes your sleep problem? (Check all that apply)

- Difficulty falling asleep
 Wake up early in the morning
 Difficulty awakening in the morning

- Wake up during the night
 Very sleepy during the day

5. Do other members of your family have sleep problems? If yes, please describe below:

6. Have you ever consulted a physician in the past for your sleep problem?

Yes No If 'Yes', what was the physician's specialty? _____

7. If you answered, "Yes" to question #6, what treatments did you receive?

9. Is your present social life satisfactory? YES NO
Does your sleep problem require you to cut back on social activity? If so, how?

10. What is your personal interpretation as to the reason for your present sleep problem?

11. What are your typical sleeping hours?

Bedtime on weekdays: _____ Rise time on weekdays: _____
Bedtime on weekends: _____ Rise time on weekends: _____

12. How many hours do you usually sleep per night? _____

13. How long does it usually take for you to fall asleep? _____ hours

14. How many times do you typically wake up at night? _____ hours

15. When you wake up at night, how long are you usually awake? _____ hours

16. If you awaken during the night, after you first fall asleep, in which part of the night does it occur?
(Check all that apply)

soon after falling asleep middle of the night early morning

17. What do you typically do while you are awake during the night?

18. Please rate the following descriptions as they occur in your situation (check one category for each question):

	Never	Sometimes	Frequently	Constantly
a) Wake up at night short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Snore loudly enough that others complain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Have trouble sleeping when you have a cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Suddenly wake up from sleep, gasping for breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Observed by others having breathing problems during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Sweat excessively during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Notice your heart beating strangely during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Fall asleep during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Fall asleep involuntarily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Fall asleep while driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Fall asleep during physical effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Fall asleep when laughing or crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Muscles become weak when extremely emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Have trouble at school or work due to sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Experience vivid dreams upon awakening or falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Feel afraid of going to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Have nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Have thoughts racing through your mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Have muscular tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Notice parts of your body jerk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Observed to have leg or foot twitches during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Experience crawling and aching feelings in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) Have morning jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) Grind teeth during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Do you usually: (Check all that apply)

- sleep with someone else in your bed
- sleep with someone else in your room
- provide assistance to someone during the night (child, spouse, animal, etc.)

20. Is your sleep often disturbed by: (check all that apply)

- heat
- cold
- light
- bed partner

- noise not being in your usual bed
 other: _____

21. Which position do you sleep in during the night: (check all that apply)
 back stomach
 right side left side

22. Do you work split shifts or rotating (variable) shifts? YES NO

23. Do you watch TV or read in bed before falling asleep? YES NO

24. Do you take naps in the afternoon or evening? YES NO

26. How do you feel after a typical night of sleep? (check one)
 tired for one hour tired most of the time
 tired for 2 hours consistently good
 tired for 3 hours

27. When do you feel best during the day? (check one)
 morning afternoon evening never feel good

28. How likely are you to fall asleep in certain situations?

The following information can be helpful to your physician in diagnosing any sleep disorder you may have. Below is a list of different situations. Using the following scale, please indicate next to each situation how likely it would be for you to fall asleep. If you have not been in some of these situations lately, simply take a guess at how likely you would fall asleep. Circle the appropriate number to indicate how likely it would be that you would fall asleep.

SITUATIONS	CHANCE OF FALLING ASLEEP			
	Would Never Fall Asleep	Slight Chance	Moderate Chance	High Chance of Falling Asleep
a) Sitting and Reading	0	1	2	3
b) Watching TV	0	1	2	3
c) Sitting inactive in a public place (theater or meeting)	0	1	2	3
d) Riding as a passenger in a car for more than 1 hour	0	1	2	3
e) Lying down to rest in the afternoon when time permits	0	1	2	3
f) Sitting and talking to someone	0	1	2	3
g) Sitting quietly after lunch (without alcohol)	0	1	2	3
h) In a car, while stopped for a few minutes in traffic	0	1	2	3

29. Review of Systems: Check any current or longstanding problems.

General:

- Fever
 Chills
 Weight loss _____#
 Weight gain _____#

Genitourinary:

- Burning with urination
 Frequency of urination
 Blood in urine
 Abnormal vaginal bleeding

- Loss of appetite
- Unusual fatigue or loss of energy
- Other _____

Eyes:

- Visual problems
- Tearing
- Drainage
- Other _____

Ears, Nose, Mouth, Throat:

- Hearing loss
- Ringing in ears
- Pain or pressure in ears
- Nasal drainage
- Difficulty swallowing
- Hoarseness
- Other _____

Cardiovascular:

- Chest pain
- Irregular heart beats
- Swelling in legs
- Pain in legs when walking
- Other _____

Gastrointestinal:

- Heartburn
- Diarrhea
- Constipation
- Blood in stools
- Nausea
- Vomiting
- Other _____

Musculoskeletal:

- Muscle weakness
- Pain or swelling in joints
- Joint stiffness
- Other _____

- Other _____

Hematology/Lymphatic:

- Abnormal bleeding
- Abnormal bruising
- Swollen glands
- Other _____

Neurologic:

- Trouble with walking or balance
- Seizures
- Numbness and tingling
- Difficulty with speech
- Headaches
- Decreased alertness
- Other _____

Psychiatric:

- Anxiety
- Depression
- Mood swings
- Other _____

Endocrine:

- Hotter or colder than others
- Flushing
- Other _____

Allergic/Immunologic:

- Food allergies _____
- Drug allergies _____
- Seasonal allergies
- Frequent infections
- Other _____

Skin:

- Rashes
- Change in color of mole
- Other _____

30. Please list all medications you are currently taking. Please include prescription medications, over-the-counter medications (ex: aspirin, allergy), herbal formulas, vitamins, etc. – even if you only use them occasionally.

	<u>NAME</u>	<u>AMOUNT</u>	<u>REASON</u>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____

d. _____

e. _____

f. _____

g. _____

h. _____

i. _____

j. _____

k. _____

l. _____

31. On average, how much of the following items do you consume each day?

Do you use this product in the evening? (6pm – 10 pm)

a. coffee (1 mug = 2 cups)	_____ cups per day	Y	N
b. colas (caffeinated)	_____ cans per day	Y	N
c. tea (caffeinated)	_____ cups per day	Y	N
d. chocolate	_____ per day	Y	N
e. nicotine	_____ packs per day	Y	N
f. beer	_____ cans/bottles per day	Y	N
b. wine	_____ glasses per day	Y	N
b. liquor	_____ ounces per day	Y	N

32. Family History:

Father Living Deceased Any medical problems? _____
 Cause of death: _____
 Age: _____

Mother Living Deceased Any medical problems? _____
 Cause of death: _____
 Age: _____

Brothers & Sisters: _____ Number Living Any medical problems? _____

_____ Number Deceased Cause of death and age. _____

33. Social History:

Single Married Divorced Widowed

Number of children: _____

Current or former occupation(s): _____

Leisure activities:

Are you currently:

Working

Unemployed

Retired

Disabled

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words “sleepy” or “tired” are used, it means the feeling that you can’t keep your eyes open, your head is droopy, that you want to “nod off”, or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Directions: Please put a check in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you generally have difficulty remembering things, because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty finishing a meal because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have difficulty working on a hobby (for example, sewing, collecting, gardening) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have difficulty operating a motor vehicle for <u>short</u> distances (less than 100 miles) because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have difficulty operating a motor vehicle for <u>long</u> distances (greater than 100 miles) because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty taking care of financial affairs and doing paperwork (for example, writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
11. Do you have difficulty maintaining a telephone conversation, because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have difficulty visiting with your family or friends in <u>your</u> home because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have difficulty visiting with your family or friends in <u>their</u> home because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have difficulty doing things for your family or friends because you are too sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(4) No	(3) Yes, a little	(2) Yes, moderately	(1) Yes, extremely	
15. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In what way has your relationship been affected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
16. Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have difficulty watching a movie or videotape because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have difficulty enjoying a concert because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have difficulty watching TV because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have difficulty participating in religious services, meetings or a group or club, because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you have difficulty being as active as you want to be in the <u>evening</u> because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have difficulty being as active as you want to be in the <u>morning</u> because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(0) I don't do this for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
24. Do you have difficulty being as active as you want to be in the <u>afternoon</u> because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have difficulty keeping pace with others your own age because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(1) Very low	(2) Low	(3) Medium	(4) High	
26. How would you rate your general level of activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	(0) I don't do this for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
27. Has your intimate or sexual relationship been affected because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(0) I don't engage in sexual activity for other reasons	(4) No	(3) Yes, a little	(2) Yes, moderately	(1) Yes, extreme
28. Has your desire for intimacy or sex been affected because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Has your ability to become sexually aroused been affected because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Has your ability to have an orgasm been affected because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>