Date:

Sleep History Questionnaire
Southeast Regional Sleep Disorders Center

Name: _____ Age: _____ Sex: ☐ Male ☐ Female SS#: _____-_____-_____

Occupation: _____ Years of Education: _____ Marital Status: ☐ Single ☐ Married

Referring Physician: _____ Family Physician: _____

Briefly describe your symptoms related to sleep and wake:

Physician Comments:

Circle ***Your symptoms while sleeping or in bed:***

Loud Snoring Stop Breathing Gasping Frequent Awakenings Restless Legs Legs Jerk

Restless Sleep Urinate/Night Dry Mouth Sleep Walking Dream Acting Bed Wetting

DIFFICULTY: Falling asleep Staying asleep Early awakening

UPON AWAKENING: Fully Rested Poorly rested Unrested Headaches

Daytime Symptoms: Sleepy Fatigue Exhaustion Normal

Complete the following:

Work hours: from _____ to _____ Bedtime _____ Time out of bed _____

Total hours of sleep _____(hours) Number of naps per day _____

Other sleep time symptoms: _____

Other wake time symptoms: _____

Circle ***Applicable Symptoms:***

1) Become weak or limp with laughter. 2) Feel paralyzed upon awakening.

3) See or hear things when closing eyes (hallucinate)

Circle ***Other Physical Symptoms:***

Pain Loss of consciousness Aching legs Arthritis Sinus infections

Fibromyalgia Nasal stuffiness or drainage Teeth grinding/Clenching

Overwhelming urge to move legs Reflux symptoms

Other symptoms: _____

Circle ***Other mental symptoms:***

Anxiety Panic Depression Bipolar Sadness Exhaustion

Other mental symptoms: _____

Have you ever had infectious mono., hepatitis, or serious viral illness? Yes No

Hove you ever had severe head injury with loss of consciousness? Yes No

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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 usual way of life in recent times.

Use the following scale to choose the most appropriate number for each situation:

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. theater or meeting)	
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	

Height: _____ Weight: _____

List Major Surgeries:

_____

_____

List Major Injuries:

_____

_____

Use this space to elaborate on any of the above problems_____

_____

_____

List Medications:	Reason for taking medications/diagnosis:

Physician Comments:

Review of Systems	WNL	See Note
Const		
Eyes		
ENT/ Mouth		
CV		
Resp		
GI		
GU		
Musc		
Skin/ Breats		
Neuro		
Psych		
Hem/ Lymph		
Allerg/ Immun		

Smoking Hx: ☐ Yes ☐ No

_____

Alcohol consumption: ☐ Yes ☐ No

_____

Caffeine intake: ☐ Yes ☐ No

_____

Family Hx of Sleep Disorders? ☐ Yes ☐ No

If yes who ? _____

What disorder?_____

List allergies to medications:

_____

_____

_____

_____ _____

Physician **Date**