

# Sleep History Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Date: \_\_\_\_\_

1. What time do you normally go to bed? \_\_\_\_\_
2. Do you have difficulty *falling* asleep at the beginning of the night? Yes or No  
If so, how long does it usually take for you to finally fall asleep? \_\_\_\_\_
3. Do you have difficulty *staying* asleep throughout the night? Yes or No
4. How many times do you usually wake up during the night? \_\_\_\_\_
5. How long does it take you to fall back asleep? \_\_\_\_\_
6. When do you normally wake up and get out of bed to start your day? \_\_\_\_\_
7. Do you feel refreshed and well rested when you get up in the morning? Yes or No
8. Do you experience sleepiness during the day? Yes or No  
If so, is the daytime sleepiness worse:  
morning \_\_\_\_\_ mid-day \_\_\_\_\_ afternoon \_\_\_\_\_ late evening \_\_\_\_\_
9. Have you ever fallen asleep while driving? Yes or No
10. Do you frequently take naps during the day? Yes or No
11. Have you ever been told that you snore at night? Yes or No
12. Have you ever been told that you stop breathing while you are sleeping? Yes or No
13. Does your bed partner sleep in another room because of the way you sleep? Yes or No
14. Do you ever experience a restless sensation in your legs that make them twitch and jerk? Yes or No  
If yes, how often? rarely \_\_\_\_\_ half of the time \_\_\_\_\_ most of the time \_\_\_\_\_
15. Do you ever awaken and feel as if your muscles are paralyzed, leaving you unable to move? Yes or No
16. Do you ever experience sudden loss of strength in your legs or arms during the day? Yes or No  
If yes, are these episodes brought on by a sudden frightening event or laughter? Yes or No
17. Do you consider yourself claustrophobic? Yes or No
18. Check all that apply to you:  
Do you frequently awaken with: dry mouth \_\_\_\_\_; gasping for air \_\_\_\_\_; excessive sweating \_\_\_\_\_;  
heartburn \_\_\_\_\_; headaches \_\_\_\_\_; chest pain \_\_\_\_\_; aching jaw from grinding teeth \_\_\_\_\_.
19. Have you ever: sleep walked \_\_\_\_\_; acted out your dreams \_\_\_\_\_; or talked in your sleep \_\_\_\_\_?  
?
20. How many caffeinated beverages do you drink per day? \_\_\_\_\_ How many after 2:00pm? \_\_\_\_\_
21. How often do you drink alcoholic beverages? never \_\_\_\_\_ occasionally \_\_\_\_\_ daily \_\_\_\_\_

## HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?

0 = never become drowsy      1 = rarely become drowsy      2 = frequently become drowsy      3 = always become drowsy

( please circle the number that applies to you )

- |   |   |   |   |   |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Sitting and reading   |
| 0 | 1 | 2 | 3 | Watching television   |
| 0 | 1 | 2 | 3 | Sitting inactive in a public place (example: doctor's office waiting room, or theater)  |
| 0 | 1 | 2 | 3 | As a passenger in a car for an hour without a break                                     |
| 0 | 1 | 2 | 3 | Lying down to rest in the afternoon when circumstances permit                           |
| 0 | 1 | 2 | 3 | Sitting and talking to someone  |
| 0 | 1 | 2 | 3 | Sitting quietly after lunch (without drinking alcohol )                                 |
| 0 | 1 | 2 | 3 | In a car, while stopping for a few minutes in traffic (example: stopped at a red light) |

My sleep problems are: \_\_\_\_\_

My current and past medical problems include: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_