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JUPITER MEDICAL CENTER SLEEP CENTER
ACHC ACCREDITED
An ACHC Accredited Sleep Facility

Sleep History Questionnaire

Name:_____ Gender: ☐ Male ☐ Female Birthdate: ___/____/_____

Address:_____ City:_____ State:_____ Zip:_____

Daytime Phone: _____ Occupation:_____

Evening Phone: _____ Years of Education:_____

Cell Phone: _____ Height: _____ Weight:_____ Neck Size:_____

EMAIL:_____ Language: ☐ English ☐ Spanish ☐ Other:_____

Who is your primary care physician?_____ Who referred you to us?_____

1. a. Please state in your own words why you (or your physician) asked for a sleep evaluation.

   b. How long have you been experiencing this problem?

2. Have you ever had a sleep study before? ☐ No ☐ Yes If "Yes" Where? When?

3. a. Do you, or have you used a CPAP or BiPAP unit in the past? ☐ Yes ☐ No If "Yes" what homecare company?

   b. Do you, or a family member in your house use Oxygen, or rented medical equipment? If YES, what company?

If you have an overnight sleep study, we need to be aware of the need for any accommodations before scheduling. Please answer the following questions completely, even if some may not apply to you. If you arrive requiring additional assistance beyond what was written below, you will be asked to re-schedule.

Would you be driving yourself to the appointment? (usually in the evening at 8:00 or 8:30 PM) ☐ YES ☐ NO
If "NOT" please explain:

Do you use a ☐ Walker? ☐ Wheelchair? ☐ Scooter? or ☐ Cane? ☐ YES ☐ NO

Do you require assistance with speech, hearing, or understanding simple instructions? ☐ YES ☐ NO

Do you require assistance getting in and out of bed? ☐ YES ☐ NO

Do you require assistance taking medications, getting dressed, eating, or using the bathroom? ☐ YES ☐ NO

Are you staying in an assisted living, group home, or have visits from a nurse, aide, or personal assistant? ☐ YES ☐ NO

Do you use OXYGEN? ☐ YES, ☐ 1 liter ☐ 2 liters ☐ 3 liters ☐ 4 liters ☐ 5 liters ☐ More than 5 liters ☐ NO

Falling Asleep:

4. What time do you usually fall asleep on a week-night? _____ am/pm Week-end night? _____ am/pm

5. How long does it usually take to fall asleep? _____ minutes.

6. **When falling asleep, or trying to sleep, are you frequently bothered by:**

[ ] Thoughts racing through your mind?
[ ] Feel muscular tension?
[ ] Feel afraid of not being able to sleep?
[ ] Creepy, crawly, achy, or twitchy feelings in legs?
[ ] Have any kind of pain or discomfort?
[ ] Suddenly become awake or alert?
[ ] Feeling sad or depressed?
[ ] Have anxiety or worry about things?
[ ] Feel unable to move?
[ ] Have vivid, dream-like images or scenes?
[ ] Feel afraid of the dark or anything else?

About your Sleep:

7. How many hours of sleep do you usually get each night? _____ hours.

8. Does your nightly amount of sleep vary?_____ from _____ to _____hours

9. How many times do you awaken each night?_____

10. On a usual night, what is your longest period of wakefulness? _____

11. Are you frequently bothered by, or told that you……..

[ ] Feel afraid you won't fall back asleep after awakening?
[ ] Have restless, disturbed sleep?
[ ] Have you been told that you snore, snort, or gasp loudly?
[ ] Feel your heart pounding during the night?
[ ] Walk in your sleep?
[ ] Wake up screaming, violent, or confused?
[ ] Wet the bed?
[ ] Grind teeth during the night?
[ ] Wake up to urinate?
[ ] Wake up with chest pain?
[ ] Wake up due to hunger, or thirst?
[ ] Wake up from bad dreams?
[ ] Wake up due to noise or movement of bedpartner?
[ ] Sleep with someone else in your bed?
[ ] Get up at night due to children, pets, family member?
[ ] Been told that you stop breathing?
[ ] Sweat a lot during the night?
[ ] Fall out of bed while asleep?
[ ] Have unusual movements while asleep?
[ ] Have dreams?
[ ] Wake because of heartburn or reflux (GERD)
[ ] Wake with restless, creepy crawly legs or leg cramps?
[ ] Wake up with shortness of breath, asthma, or choking?
[ ] Wake up due to heat, cold, or noise?
[ ] Wake up from too much light in the bedroom?

12. What are your usual work hours? Start _____ am/pm End:_____ am/pm Any on-call?_____

13. Does your work involve rotating or changing shifts? □ No □ Yes If YES, how often?

About waking up:

14. What time do you usually awaken?_____ am/pm.

15. Does your final awakening vary over a 30 day period? **Earliest**_____ am/pm **Latest**:_____am/pm

16. When waking up, do you often:

[ ] Depend on an alarm to wake up?
[ ] Feel unable to move (paralyzed?)
[ ] Have vivid, dream like images when waking?
[ ] Wake up with a headache?
[ ] Wake up with a dry mouth?
[ ] Have a hard time waking up?
[ ] Wake up sick to your stomach?
[ ] Wake up disoriented or confused?
[ ] Wake up 1-2 hours earlier than you want to?

About Daytime Activities & Alertness

17. How many naps do you take in a typical week? _____ If, YES, how long are your naps? _____
18. Are the naps refreshing and do they restore alertness? □ Yes □ No
19. During the day, or your normal time awake, do you often,

[ ] Feel sleepy during the day, where you could easily sleep
[ ] Actually fall asleep while driving or stopped at a light
[ ] Feel weak or fall down if surprised, angry, or excited
[ ] Worry about things (anxiety)
[ ] Feel muscular tension or stress
[ ] Fall asleep at work or at social events

Other Information:

20 Are there any other blood relatives in your family with a sleep problem? Please describe.

21. How many of the following drinks do you have on a daily basis.

	Typical Day	**0 - 4 hours before bed**
a. Coffee or tea **with** caffeine	_____ cups	_____ cups
b. Soda or pop **with** caffeine	_____ cans	_____ cans
c. Beer/Wine/Other	_____ ea	_____ ea

22. Do you now smoke or use any type of tobacco product? □ No □ Yes
23. If no, did you **EVER** smoke or use any type of tobacco? □ No □ Yes, quit _____ years ago
24. What type(s) of tobacco do you, or did you use **per day?** _____
25. Please list any sleeping pill used to help you fall asleep or stay asleep or any medication used to stay awake & alert that you have taken in the **PAST.**

Name of pill and dose (amount)	**How long did you take it?**	**Was it helpful?**

26. What medications are you allergic to? _____

27. What prescribed medications do you take daily? If numerous, please attach list.

28. What conditions are you being treated for or frequently experiencing (check all that apply):

☐ Asthma	☐ Use Oxygen	☐ COPD/Emphysema	☐ Frequent pneumonia	☐ Tuberculosis (TB)
☐ Lung cancer	☐ Sleep apnea	☐ Pulmonary fibrosis	☐ Severe allergies	☐ Eczema
☐ Pacemaker	☐ Narcolepsy	☐ Heart failure (CHF)	☐ Atrial fibrillation	☐ High blood pressure
☐ Anxiety	☐ Kidney disease	☐ Diabetes	☐ Low blood sugar	☐ Anemia
☐ Arthritis	☐ Fibromyalgia	☐ Chronic back pain	☐ Stroke	☐ Syncope/fainting
☐ Cancer	☐ High cholesterol	☐ Thyroid problems	☐ Hepatitis / liver disease	☐ Incontinence
☐ Lupus	☐ Prostate trouble	☐ Crohns disease	☐ Irritable bowel	☐ Immune disorder
☐ Depression	☐ Seizures	☐ Bi polar depression	☐ Post traumatic stress	☐ Other psychiatric condition
☐ Alzheimers	☐ Dementia	☐Parkinson's	☐ M.S., ALS, M.D,	☐ Digestive troubles
☐ Nose surgery	☐ Sinus surgery	☐ Neck or jaw surgery	☐ UPPP or somnoplasty	☐ Cleft palate repair
☐ Tonsillectomy	☐ Tracheostomy	☐ Gastric bypass	☐ GERD / Heartburn / Reflux	
☐ Restless legs or PLMD				

☐ Amputee (what limb?) _____ ☐ Skin grafts or burns (where?) _____

Past Surgery: ☐ Heart ☐ Lung ☐ Throat ☐ Jaw ☐ Neck ☐ Nose ☐ Sinus ☐ Ear ☐ Eye ☐ Brain
☐ Spine/Back ☐ Chest ☐ Abdomen ☐ Pelvic ☐ Hip ☐ Knee ☐ Leg ☐ Shoulder ☐ Stomach ☐ Bowel

BED-PARTNER OBSERVATIONS: (*TO BE COMPLETED BY SPOUSE, SIGNIFICANT OTHER, OR FAMILY MEMBER*)

29. Please check off any of the following that you have frequently observed the patient doing **WHILE ASLEEP.**

	All Night	Parts of night	If tired	If alcohol	Rarely	Never
Light Snoring?	☐	☐	☐	☐	☐	☐
Loud Snoring heard through door, or in other rooms?	☐	☐	☐	☐	☐	☐
Choking or stop breathing?	☐	☐	☐	☐	☐	☐
Twitching, jerking, kicking of arms or legs in sleep?	☐	☐	☐	☐	☐	☐
Sleep talking or Walking?	☐	☐	☐	☐	☐	☐
Crying out screaming or moaning?	☐	☐	☐	☐	☐	☐
Unusual violent activity, punching, kicking, grabbing?	☐	☐	☐	☐	☐	☐
Eating food, other objects while appearing to be asleep?	☐	☐	☐	☐	☐	☐
Biting tongue, causing it to bleed?	☐	☐	☐	☐	☐	☐
Been extremely difficult to awaken, or extremely groggy?	☐	☐	☐	☐	☐	☐

30. EPWORTH SLEEPINESS SCALE TO BE COMPLETED BY PATIENT ONLY

This scale is used to determine how likely you are to doze off or fall asleep in various situations, in contrast to just feeling tired. Even if you have not done some of these things, please try to work out how they would have affected you.

What is the chance you will doze off or fall asleep even briefly in the following situations?

Circle one for each question:

	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and Reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting inactive in a public place, (such as a theater or meeting)	**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 it.	**0**	**1**	**2**	**3**
Sitting and talking with someone	**0**	**1**	**2**	**3**
Sitting quietly after a lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**