

SLEEP HEALERS

Sleep History Questionnaire

Name: _____ Age: _____ SS#: _____ Date: _____
 Male Female Height: _____ Weight: _____ lbs. Marital Status : M S D W
Occupation: _____ Emergency Name / Ph #: _____
Primary Care Physician: _____ Referring Physician: _____

Medical History

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Nose Fracture |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dental Appliance |
| <input type="checkbox"/> Hiatal Hernia / Reflux | <input type="checkbox"/> Stroke | <input type="checkbox"/> ENT Surgery/Pillar Implant | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> COPD (emphysema, bronchitis) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Seizures |
- Sleep Disorder: _____ Current Medications: (Include Separate Sheet for 5 or more)
 Medication allergies: _____ 1. _____
 Smoking: # of years: _____ Packs per day: _____ 2. _____
Have you quit? Yes No When? _____ 3. _____
 Recent change in weight: _____ 4. _____

On an average night:

What is your usual bedtime? _____
How long does it take you to fall asleep? _____ min.
How many hours do you spend in bed? _____ hours
How many hours do you sleep at night? _____ hours
Number of awakenings: _____
Length of awakenings: _____ min.
What time do you get out of bed in the morning? _____
Do you feel refreshed in the morning? Yes No
Do you awaken with a headache? Yes No

Do you or have you ever been told that you:

Grit or grind your teeth? Yes No
Have night sweats? Yes No
Experience leg cramps or tingling? Yes No
Repeatedly kick your legs while asleep? Yes No
Awaken with a sour or bitter taste in your mouth? Yes No
Hold your breath while you sleep? Yes No
Awaken choking, gasping, or short of breath? Yes No
Fall asleep unintentionally? Yes No
Snore? Since when? _____ Yes No

Do you experience any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Snoring interrupted by silence / gasping |
| <input type="checkbox"/> Disruptive Snoring | <input type="checkbox"/> Snore worse on your: <input type="checkbox"/> Back <input type="checkbox"/> Side |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Falling asleep at inappropriate times |
| <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Somnolence or Drowsiness |
| <input type="checkbox"/> Talking in Sleep | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Loss of Libido |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Fatigue or Malaise |

Do You ever:

- Read while in bed?
 Watch TV in bed? (or your bed-partner does)
 Share your bed with anyone? _____
 Take naps? How long? _____
Are they refreshing? Yes No
 Awaken to urinate during the night?
How often? _____

Are you experiencing excessive daytime sleepiness? Yes No Since when? _____
Are you bothered by feelings of restlessness, or need to move your legs, or pace when sitting for long periods of time? Yes No
During Awakenings? Yes No When trying to fall asleep? Yes No During the night? Yes No
Do you experience vivid dream-like episodes or feel paralyzed when waking or falling asleep? Yes No
Do you feel anxious, depressed or irritable? Yes No If yes, please explain below.

Please explain your sleep problem: _____

