UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH
SLEEP DISORDERS CENTER

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PATIENT SLEEP HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Sex: _____ Date: _____

Referring Physician: _____ Family Physician (PCP): _____

Occupation: _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Family History

Has an immediate blood relative had any of the following?

❑ Sleep Apnea _____
❑ Restless legs _____
❑ Narcolepsy _____

I have had a previous overnight sleep study. ❑ Yes ❑No When/Where? _____

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night How many months/years? _____
❑ Being sleepy all day How many months/years? _____
❑ Snoring How many months/years? _____
❑ Unwanted behaviors during sleep Explain: _____
❑ Other; Explain _____

Please check all of the following statements that are true about your sleep:

Breathing

❑ I have been told that I stop breathing while I sleep
❑ I wake up at night choking, smothering or gasping for air
❑ I have been told that I snore ❑mildly, occasionally ❑frequently, moderately ❑constantly, severely
❑ I have been told that I snore only when sleeping on my back
❑ I have been awakened by my own snoring
❑ My bedpartner is bothered significantly by my snoring

Daytime Sleepiness

❑ I have had "blackouts" or periods when I am unable to remember what just happened
❑ I have fallen asleep while driving or feel my driving is affected by sleepiness
❑ I have had an auto accident as a result of falling asleep while driving
❑ I fall asleep easily in quiet situations
❑ I perform poorly in school or work because of sleepiness
❑ I have had injuries as the result of sleepiness
❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
❑ I have had an inability to move while falling asleep or when waking up
❑ I have had hallucinations or vivid dreamlike images or sounds when falling asleep or waking up

Restlessness/Parasomnia

❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
❑ I have a hard time falling asleep because of my leg movements
❑ Leg restlessness delays my sleep ❑ often ❑ occasionally ❑ rarely

- ❑ I have been told that I kick or jerk my legs and/or arms frequently during sleep
- ❑ I frequently talk in my sleep
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep ❑ I use a guard to protect my teeth from grinding
- ❑ I have acted out dreams physically while asleep
- ❑ I have injured myself or others with movement during the night

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I often drink alcohol prior to bedtime
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I cannot sleep on my back ❑ I can only sleep on my back ❑ I need elevation of the head of my bed
- ❑ I sleep alone ❑ I share a bed with someone
- ❑ I am a shift worker on rotating shifts
- ❑ I frequently have trouble with insomnia

	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
Typical wake up time:	_____a.m./p.m.	_____ a.m./p.m.
Total amount of sleep per night:	_____hours	_____hours
Number of naps per day/duration:	_____	_____

Usual Work Days: _____ Usual Work Hours: _____

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

0 = Would never doze 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., a theater or meeting)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____

Vital Statistics

What is your: Height? ____ feet _____inches Weight? _____ pounds Neck Size: _____

Current Medications *(please list or provide a list)*

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day

Allergies: _____

Habits

Do you smoke or have you smoked? ❑ Yes, currently ❑ No, never ❑ Previously

If Yes: ❑ Cigarettes _____ pack(s)/day _____ years

If Previously: When did you quit? _____ How much did you smoke? _____

For how many years did you smoke? _____

Do you drink alcohol? ❑ Yes ❑ No

If Yes: What? ❑ Beer ❑Wine ❑Liquor

Frequency? _____ drinks per ❑Day ❑Week ❑ Month

Do you drink caffeinated beverages during the day? _____ # of cups/bottles/cans/oz per day _____

Type of drinks: ❑coffee ❑tea ❑soda My last caffeinated drink is usually: _____ am/pm

Past Medical History *(please indicate any medical problems you experienced)*

- ❑ Neurological Disorders
- ❑ Stroke or mini stroke (TIA)/head injury
- ❑ Seizures
- ❑ Chronic sinus disease
- ❑ Hearing impairment
- ❑ Dental Problems
- ❑ Cardiac Disorders
- ❑ Heart Disease/Coronary Artery Disease
- ❑ Heart Attack
- ❑ Hypertension (high blood pressure)
- ❑ Lung problems
- ❑ Asthma
- ❑ COPD
- ❑ Lung Cancer
- ❑ Stomach or colon problems
- ❑ Reflux problems
- ❑ Erectile dysfunction/impotence
- ❑ Prostate problems
- ❑ Perimenopausal/hot flashes
- ❑ Menopause
- ❑ Back or joint Disorders
- ❑ Arthritis
- ❑ Back Pain
- ❑ Fibromyalgia/chronic pain
- ❑ Endocrine Disorders
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Infectious Diseases
- ❑ Hepatitis/jaundice
- ❑ Alcoholism/Chemical Dependency or Abuse
- ❑ Severe anxiety
- ❑ Depression

List any other important past medical problems/surgeries:

_____

_____

_____