



Leaders in helping you breathe easy & sleep well.

Thomas M. Siler, MD, FCCP, FAASM
Pulmonary Disease & Sleep Medicine Specialist

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Mitchell P. Champagne, RPh, CCRC
Research Director

Susan L. Townsley, RPSGT, RRT, RPFT
Sleep Coordinator

Experienced, comprehensive & highly capable care for...

- Infection, disease & cancer of the lungs
- Coughing, wheezing & shortness of breath
- Fluid in the lungs & uncontrolled edema
- Chest tightness
- Coughing up blood
- Sore throat
- Snoring & sleep apnea
- Excessive daytime sleepiness & drowsy driving
- Restless leg syndrome & periodic limb movement disorder
- Insomnia
- Narcolepsy

Advanced, credentialed & dedicated...

- Board-certified pulmonology & sleep medicine specialists
- Experienced pulmonary researchers
- Available clinical trials for eligible patients
- Advanced capabilities & technologies
- Three nurse practitioners on staff
- The region's first & only AASM-accredited sleep center
- Friendly & knowledgeable registered sleep technologists
- Individualized, compassionate care

Making it easy to get the focused care you need...

- Lunchtime appointments available
- Insurance accepted & filed
- Visa, MasterCard & Discover cards welcome
- Free parking, including valet parking
- Handicapped-accessible

SLEEP HISTORY/LIFE HISTORY QUESTIONNAIRE

Today's Date: _____ / _____ / _____
month day year

Patients Name: _____

Date of birth: _____ / _____ / _____ Height: _____ Weight: _____
month day year

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your sleep history. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE

1. **DESCRIBE YOUR MAIN SLEEP PROBLEM(S) IN YOUR OWN WORDS, INCLUDING WHEN AND HOW THIS BEGAN AND WHAT TREATMENT YOU HAVE RECEIVED FOR THIS IN THE PAST.**

2. **HOW OFTEN DOES THIS PROBLEM OCCUR?**

- almost every night
- for periods of at least 1 week
- irregularly
- other _____

3. **HOW LONG HAS THIS PROBLEM BOTHERED YOU?**

- longer than 2 years
- 1 – 2 years
- several months
- within the last 3 months
- within the last month



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4. ON THE SCALE BELOW, PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM(S).

- mildly upsetting
- moderately severe
- very severe
- extremely severe
- totally incapacitating

5. HOW STRONGLY DO YOU WANT HELP WITH YOUR PROBLEM(S)?

- very much
- much
- moderately
- could do without it

6. HOW DO YOU DESCRIBE YOUR SLEEP PROBLEM? CHECK ALL THAT APPLY TO YOU.

- difficulty falling asleep
- wake up during the night
- wake up early in the morning
- excessive daytime sleepiness
- difficulty awakening

7. DO ANY OTHER MEMBERS OF YOUR FAMILY HAVE SLEEP PROBLEMS? Yes _____ No _____

If yes, Please explain.

8. HAVE YOU EVER CONSULTED WITH ANY OF THE FOLLOWING TO HELP YOU WITH A SLEEP PROBLEM OR DAYTIME SLEEPINESS?

- | | |
|--|--|
| <input type="checkbox"/> General practitioner | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Obstetrician/Gynecologist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Other internists | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Other physician | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Clinical psychologist | <input type="checkbox"/> Clergyman |
| <input type="checkbox"/> Other _____ | |

9. WHAT TREATMENTS HAVE YOU RECEIVED?



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Rating Scale: (please circle the letter that corresponds with your answer)

N=No or Never **R**=Rarely **O**=Occasionally **F**=Frequently **A**=Always **Y**=Yes

10. **PLEASE RATE HOW OFTEN YOU:**

• Snore	N	R	O	F	A	Y
• Snore loudly enough that others complain	N	R	O	F	A	Y
• Have trouble sleeping when you have a cold	N	R	O	F	A	Y
• Awaken from sleep short of breath	N	R	O	F	A	Y
• Suddenly wake up gasping for breath during the night	N	R	O	F	A	Y
• Have breathing problems during the night (noted by self or others)	N	R	O	F	A	Y
• Awaken at night with heartburn or belching	N	R	O	F	A	Y
• Awaken at night with cough	N	R	O	F	A	Y
• Sweat excessively at night	N	R	O	F	A	Y
• Notice heart pounding or beating irregularly at night	N	R	O	F	A	Y
• Fall asleep during the day	N	R	O	F	A	Y
• Fall asleep involuntarily	N	R	O	F	A	Y
• Fall asleep while driving	N	R	O	F	A	Y
• Have trouble at school or work because of sleepiness	N	R	O	F	A	Y
• Fall asleep or weakness during physical effort	N	R	O	F	A	Y
• Fall asleep or weakness while laughing or crying	N	R	O	F	A	Y
• Experience loss of muscle tone with extreme emotions	N	R	O	F	A	Y
• Unable to move when waking or falling asleep	N	R	O	F	A	Y
• Experience vivid dreamlike scenes upon awakening or falling asleep	N	R	O	F	A	Y
• Feel afraid of going to sleep	N	R	O	F	A	Y
• Have nightmares	N	R	O	F	A	Y
• Have thoughts racing through your mind	N	R	O	F	A	Y
• Feel sad or depressed	N	R	O	F	A	Y
• Have anxiety (worry about things)	N	R	O	F	A	Y
• Have muscular tension	N	R	O	F	A	Y
• Notice parts of your body jerk	N	R	O	F	A	Y
• Kick during the night	N	R	O	F	A	Y
• Experience crawling and achy feelings in your legs	N	R	O	F	A	Y
• Have morning jaw pain	N	R	O	F	A	Y
• Grind teeth during sleep	N	R	O	F	A	Y
• Are bothered by pain during the night	N	R	O	F	A	Y
• Wake up feeling stiff in the morning	N	R	O	F	A	Y
• Wake up with sore or achy muscles	N	R	O	F	A	Y
• Wake up with pain in neck, spine, or joints	N	R	O	F	A	Y

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11. **IS YOUR PRESENT WORK SITUATION SATISFACTORY? (PLEASE EXPLAIN)**

12. **CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:**

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> No appetite | <input type="checkbox"/> Feel panicky |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Suicidal ideas |
| <input type="checkbox"/> Bowel disturbances | <input type="checkbox"/> Take drugs | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Over-ambitious |
| <input type="checkbox"/> Feel tense | <input type="checkbox"/> Unable to have good time | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Depressed | <input type="checkbox"/> Inferiority feelings |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Tremors | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Don't like weekends/vacations | <input type="checkbox"/> Fainting spells | |
| <input type="checkbox"/> Home conditions bad | <input type="checkbox"/> Can't make friends | |
| <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Can't keep a job | |
| <input type="checkbox"/> Shy with people | <input type="checkbox"/> Take antacids regularly | |
| <input type="checkbox"/> Others: _____ | | |

13. **CHECK ANY OF THE FOLLOWING WORDS THAT APPLY TO YOU:**

- | | | |
|--|--|--|
| <input type="checkbox"/> worthless | <input type="checkbox"/> useless | <input type="checkbox"/> a "nobody" |
| <input type="checkbox"/> "life is empty" | <input type="checkbox"/> inadequate | <input type="checkbox"/> stupid |
| <input type="checkbox"/> incompetent | <input type="checkbox"/> naïve | <input type="checkbox"/> guilty |
| <input type="checkbox"/> evil | <input type="checkbox"/> morally wrong | <input type="checkbox"/> horrible thoughts |
| <input type="checkbox"/> hostile | <input type="checkbox"/> full of hate | <input type="checkbox"/> "can't do anything right" |
| <input type="checkbox"/> full of regrets | <input type="checkbox"/> anxious | <input type="checkbox"/> agitated |
| <input type="checkbox"/> cowardly | <input type="checkbox"/> unassertive | <input type="checkbox"/> panicky |
| <input type="checkbox"/> aggressive | <input type="checkbox"/> ugly | <input type="checkbox"/> deformed |
| <input type="checkbox"/> unattractive | <input type="checkbox"/> depressed | <input type="checkbox"/> lonely |
| <input type="checkbox"/> unloved | <input type="checkbox"/> misunderstood | <input type="checkbox"/> bored |
| <input type="checkbox"/> restless | <input type="checkbox"/> confused | <input type="checkbox"/> unconfident |
| <input type="checkbox"/> worthwhile | <input type="checkbox"/> sympathetic | <input type="checkbox"/> intelligent |
| <input type="checkbox"/> attractive | <input type="checkbox"/> confident | <input type="checkbox"/> considerate |
| <input type="checkbox"/> Others: _____ | | |

14. **DOES YOUR SLEEP PROBLEM DISTURB YOUR SEX LIFE? (PROVIDE ANY INFORMATION REGARDING SIGNIFICANT RELATIONSHIPS.)**



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15. **IS YOUR PRESENT SOCIAL LIFE SATISFACTORY?** Yes _____ No _____

**IF YES, DOES YOUR SLEEP PROBLEM REQUIRE YOU TO CUT BACK ON SOCIAL ACTIVITY?
IF SO, HOW?**

16. **HOW MANY HOURS OF SLEEP DO YOU USUALLY GET PER NIGHT?** _____

17. **WHAT TIME DO YOU USUALLY GO TO BED ON:** WEEKDAYS? _____ WEEKENDS? _____

18. **HOW LONG DOES IT TAKE FOR YOU TO FALL ASLEEP?** _____

19. **HOW MANY TIMES DO YOU TYPICALLY WAKE UP AT NIGHT?** _____

20. **IF YOU "WAKE UP," ON THE AVERAGE, HOW LONG DO YOU STAY AWAKE?** _____

21. **IF YOU AWAKEN DURING THE NIGHT (AFTER YOU FIRST FALL ASLEEP) WHICH PARTS OF YOUR SLEEP PERIOD IS IT?**
 soon after falling asleep middle of the night early morning

22. **WHAT DO YOU USUALLY DO WHEN YOU AWAKEN DURING THE NIGHT?** _____

23. **WHAT TIME DO YOU USUALLY GET OUT OF BED ON:** WEEKDAYS? _____ WEEKENDS? _____

24. **ON AVERAGE, HOW LONG DO YOU STAY IN BED AFTER WAKING UP IN THE MORNING?** _____

25. **DO YOU USUALLY:** (check all that apply to you)
 sleep with someone in your bed
 sleep with someone else in your room
 provide assistance during the night (child, invalid, bed partner, animal)

26. **IS YOUR SLEEP OFTEN DISTURBED BY:**
 heat
 light
 cold
 bed partner
 noise
 not being in your usual bed
 other:



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27. **ARE YOUR SLEEP HABITS ON THE WEEKENDS DIFFERENT FROM THE REST OF THE WEEK?**
IF SO PLEASE DESCRIBE:

28. **WITH WHOM ARE YOU NOW LIVING?**

- Wife - age _____
- Husband - age _____
- children - age _____
- parents - age _____
- other - age _____

29. **DO YOU WORK SPLIT SHIFTS OR ROTATING (VARIABLE) SHIFTS?** Yes _____ No _____

30. **DO YOU USUALLY DRINK COFFEE OR TEA WITHIN 2 HOURS BEFORE YOU GO TO BED?**
Yes _____ No _____

31. **DO YOU DO PHYSICAL EXERCISE BEFORE BEDTIME?** Yes _____ No _____

32. **DO YOU READ BEFORE FALLING ASLEEP?** Yes _____ No _____

33. **DO YOU WATCH TV IN BED BEFORE FALLING ASLEEP?** Yes _____ No _____

34. **DO YOU TAKE NAPS DURING THE AFTERNOON OR EVENING?** Yes _____ No _____

35. **DO YOU FEEL REFRESHED AFTER A SHORT (10 – 15 MINUTE) NAP?** Yes _____ No _____

36. **HOW DO YOU FEEL AFTER AN AVERAGE NIGHT OF SLEEP?**

- Usually drowsy and/or tired
- If so, for how long: 1 hour 2 hours 3 hours or longer
- most of the time, good
- consistently good

37. **DO YOU FEEL BETTER DURING THE:**

- morning
- afternoon
- evening



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38. LIST YOUR CONSUMPTION OF THE FOLLOWING PER DAY:

Coffee _____ Alcohol _____
Tea _____ Colas _____
Chocolate _____ Over-the-counter drugs _____
Nicotine _____ Other drugs _____

39. HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO JUST FEELING TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO ESTIMATE HOW THEY WOULD HAVE AFFECTED YOU.

USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

- 0** = would never doze
- 1** = slight chance of dozing
- 2** = moderate chance of dozing
- 3** = high chance of dozing

SITUATION:

Sitting and reading _____
Watching TV _____
Sitting, inactive in a public place (ex: a theater or a 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 with someone _____
Sitting quietly after a lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

40. WHAT IS YOUR PERSONAL INTERPRETATION AS TO WHY YOU HAVE YOUR PARTICULAR SLEEP/WAKE PROBLEM?

41. PLEASE DESCRIBE ANY OTHER INFORMATION PERTINENT TO YOUR SLEEP OR WAKEFULNESS NOT PREVIOUSLY DESCRIBED.

