midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

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

midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

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?

◻ General practitioner	◻ Chiropractor	◻ Obstetrician/Gynecologist
◻ Cardiologist	◻ Other Internists	◻ Psychiatrist
◻ Other Physician	◻ Clinical Psychologist	◻ Osteopath
◻ Nutritionist	◻ Counselor	◻ Social Worker
◻ Nurse	◻ Clergyman	◻ Other _____

9. What treatments have you received?

_____

_____

_____

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

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 walking 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 feeling 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

11. Is your present work situation satisfactory? (Please explain)

midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

12. **CHECK** any of the following that apply to you:

☐ Headaches	☐ No appetite	☐ Feel panicky
☐ Palpitations	☐ Alcoholism	☐ Suicidal ideas
☐ Bowel disturbances	☐ Take drugs	☐ Sexual problems
☐ Nightmares	☐ Can't make decisions	☐ Over-ambitious
☐ Feels tense	☐ Unable to have a good time	☐ Memory problems
☐ Financial problems	☐ Depressed	☐ Inferiority problems
☐ Unable to relax	☐ Tremors	☐ Stomach trouble
☐ Don't like weekends/vacations	☐ Fainting Spells	☐ Home conditions bad
☐ Can't make friends	☐ Concentration difficulties	☐ Can't keep job
☐ Shy with people	☐ Take antacids regularly	

☐ Others: _____

13. **CHECK** any of the following words that apply to you:

☐ Worthless	☐ useless	☐ a "nobody"
☐ "life is empty"	☐ inadequate	☐ stupid
☐ incompetent	☐ naïve	☐ guilty
☐ evil	☐ morally wrong	☐ horrible thoughts
☐ hostile	☐ full of hate	☐ "can't do anything right"
☐ full of regrets	☐ anxious	☐ agitated
☐ cowardly	☐ unassertive	☐ panicky
☐ aggressive	☐ ugly	☐ deformed
☐ unattractive	☐ depressed	☐ lonely
☐ unloved	☐ misunderstood	☐ bored
☐ restless	☐ confused	☐ unconfident
☐ worthwhile	☐ sympathetic	☐ intelligent
☐ attractive	☐ confident	☐ considerate

☐ Others: _____

14. Does your sleep problem disturb your sex life? (Provide any information regarding significant relationships.)

_____

_____

_____

_____

midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

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 ☐ not being in your usual bed
    ☐ Other: _____

27. Are your sleep habits on the weekend different from the rest of week?
    If so please describe:

_____

_____

midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

28. With whom are you now living?
    - ☐ Wife – age _____
    - ☐ Husband – age_____
    - ☐ Children – age(s)_____
    - ☐ Parents – age(s)_____
    - ☐ 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

38. List your consumption of the following per day:

Coffee_____	Alcohol_____
Tea_____	Colas_____
Chocolate_____	Over-the-Counter Drugs_____
Nicotine_____	Other Drugs_____

midwest chest consultants

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
V. Christine Champagne, N.P.
Sara Springer, N.P.
Angela K. McDonnell, N.P.
Mitchell P Champagne RPh, CCRC

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 chose 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.

_____

_____

_____

_____