SLEEP HISTORY

Patient name:_____ Date of Birth:_____

What is your main sleep problem? _____

How long have you had this problem? _____

Please list any previously diagnosed sleep disorders._____

Do you take anything to help you sleep? YES or NO

If yes, what? _____How often? _____

What medicines have you used previously?_____

Check any of the following that apply:

___ Loud snoring
___ Breathing or snoring stops in my sleep
___ I have had an automobile accident as the driver
___ Awaken gasping for breath
___ Do not feel restored when I awaken
___ Difficulty falling asleep
___ Difficulty remaining asleep
___ Awaken too early
___ Become sleepy during the day

(Please circle any/all that apply)

___sitting ___talking
___riding ___eating
___driving ___standing

Sleep Environment

My bedroom is loud or quiet and light or dark

My mattress is soft or hard or just right?

Do you go to sleep with the television on? YES or NO

your sleep disturbed because of your bed partner or others in your household (children or pets)? YES or NO

Occupation

What do you usually do at work?_____

How does your sleep problem affect your work?

Do you work at night? YES or NO

Epworth Sleepiness Scale

How like are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 work out 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:

0 1 2 3 -Sitting and reading
0 1 2 3 -Watching TV
0 1 2 3 -Sitting, inactive, in a public place (e.g., a theater or meeting)
0 1 2 3 -As a passenger in a car for a hour without Is a break
0 1 2 3 -Lying down to rest in the afternoon when circumstances permit
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

EES Total _____

Previously diagnosed sleep disorders and treatment:

_____
_____
_____
_____
_____
_____
_____

History of surgery:_____

_____

Indicate ON AVERAGE how often you experience the following symptoms:

Times weekly	Symptom
	My mind races with many thoughts when I try to fall asleep.
	I often worry whether or not I will be able to fall asleep.
	Fatigue
	Anxiety
	Memory impairment
	Inability to concentrate
	Irritability
	Depression
	Awaken with a dry mouth
	Morning headaches
	Pain which delays or prevents my sleep
	Pain which awakens me from sleep
	Vivid or lifelike visions (people in room, etc.) as you fall asleep or wake up
	Inability to move as you are trying to go to sleep or wake up
	Sudden weakness or feel your body go limp when you are angry or excited
	Irresistible urge to move legs or arms
	Creeping or crawling sensation in legs before falling asleep
	Legs or arms jerking during sleep
	Sleep talking
	Sleep walking
	Nightmares
	Fall out of bed
	Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
	Bed-wetting
	Frequent urination disrupting sleep
	Teeth grinding
	Wheezing or cough disrupting sleep
	Sinus trouble, nasal congestion, or post-nasal drip interfering with sleep
	Shortness of breath disrupting sleep
	other

Please be as accurate as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week, then indicate your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	Shift work
Lay down in bed			
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
Final wake up from sleep			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
If you take naps, how long?			
Begin work time			
End work time			