PATIENT HISTORY QUESTIONNAIRE

Patient: ___________________________ Date: _______________

1. Why has your physician ordered a sleep study for you? ___________________________________

2. How long have you had problems sleeping? ____

3. What techniques have you tried to help yourself sleep? ____________________________________

4. Do you snore? Yes_____ No________ If yes, explain: ________________________________

5. Has anyone told you that you stop breathing in your sleep? Yes________ No__________
If yes, explain: ____

6. Do you feel groggy during the day? Yes__________ No____________
If yes, explain: ____

7. Have you stopped driving because of excessive sleepiness? Yes___________ No______
If yes, explain:
____

8. If left unstimulated, would you fall asleep? Yes__________ No_______________________
If yes, explain:
____

9. Do you awaken short of breath? Yes_________ No___________
If yes, explain:
____

10. Do you awaken with a bitter taste in your mouth? Yes___________ No______________
If yes, explain:
____

11. Do you experience any type of leg pain? Yes_____________ No_____________________
If yes, explain:
____

12. Do you have vivid dreams upon falling asleep or waking up? Yes_________ No___________
If yes, explain:
____

13. Are you unable to move or speak upon falling asleep or waking up? Yes________ No__________
If yes, explain:
____

14. Do you smoke? Yes__________________ No_______________________________________

15. Do you have difficulty falling back to sleep after awakening? Yes_________ No____________

If yes, explain: ____

16. Do you feel tense, irritable or depressed? Yes______________ No______________________
If yes, explain: ____

17. Do you work shift work? Yes_______________ No______________________
If yes, explain: ____

18. Do your drink beverages with caffeine in the afternoon or evening? Yes__________ No_____
If yes, explain: ____

19. Do you drink alcoholic beverages? Yes_______________ No_________________________
If yes, explain: ____

20. Do you have trouble falling asleep because of worry? Yes_____________ No_____________
If yes, explain: ____

21. Are you taking prescribed medications?

Name	Date	Frequency	Reason

22. Are you taking any over-the-counter medications? Yes______________ No_______________
If yes, what

____

____

23. Do you often find yourself falling asleep when you don't intend to, such as watching TV?
Yes_____________ No_______________________

24. Does excessive sleepiness interfere with your work? Yes____________ No_____________
If yes, explain:
____

25. Do you awaken with a headache? Yes_________________ No____________________
If yes, explain: ____

26. Do your muscles feel very weak when you are laughing, excited or angry? Yes______ No____
If yes, explain: ____

27. Do you have trouble concentrating or remembering things during the day? Yes_____ No_____
If yes, explain: ____

28. Do you hear, feel, or see things when you are falling asleep or waking up? Yes______ No____
If yes, explain: ____

29. Do you have night sweats? Yes______________ No_______________________
If yes, explain:
____

30. Are you a restless sleeper? Yes____________ No_______________________
If yes, explain:
____

31. Do your legs jerk or feel uncomfortable before or during sleep? Yes________ No________
If yes, explain:
____

32. Have you walked in your sleep recently? Yes____________ No____________________
If yes, explain:
____

33. Have you fallen out of bed recently? Yes___________ No_______________________
If yes, explain:
____

34. Do you grind your teeth at night? Yes________________ No______________________
If yes, explain:
____

35. Do you awaken with jaw pain? Yes_____________ No___________________________
If yes, explain:
____

36. What type of work do you do? ____

37. How tall are you?
____

38. How much do you weigh? ____

39. Do you have any other medical problems? Yes_____________ No___________________
If yes, explain: ____