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**Sleep History Questionnaire**

Date:	Patient Name:	DOB:	
Referring Physician:		Primary Physician:	
If no Referring Physician, how did you hear about us:			
Preferred Language:	Ethnicity:	Race:	
Height:	Present Weight:	Weight 1 year ago:	Weight High School:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been told you snore?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you excessively tired during the day?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been told you stop breathing during sleep?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of hypertension?  |
|                          |                          | Blood pressure: _____/_____   |
|                          |                          | Heart rate: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your neck size greater than 17 inches (male) or greater than 16 inches (female)? |
|                          |                          | Indicate Neck circumference: _____ inches   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wake up to use the bathroom more than twice a night?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have aching or restlessness in your legs at night with an urge to move them? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you awake in the morning feeling refreshed?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Any history of accidents (work or car) due to sleepiness? Describe: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently use a sleep aid? Name of medication: _____                         |

**Epworth Sleepiness Scale**

Please rate on a scale of 0-3 how likely you are to doze off in each of the following situations.  
 0 = would NEVER doze    1 = SLIGHT chance of dozing    2 = MODERATE chance of dozing    3 = HIGH chance of dozing

- |       |   |   |   |   |
|-------|---|---|---|---|
| 0     | 1 | 2 | 3 | Sitting and reading   |
| 0     | 1 | 2 | 3 | Watching TV   |
| 0     | 1 | 2 | 3 | Sitting, inactive, in a public place                          |
| 0     | 1 | 2 | 3 | As a passenger in a car for an hour without a break           |
| 0     | 1 | 2 | 3 | Lying down to rest in the afternoon when circumstances permit |
| 0     | 1 | 2 | 3 | Sitting and talking to someone                                |
| 0     | 1 | 2 | 3 | Sitting quietly after lunch                                   |
| 0     | 1 | 2 | 3 | In a car, while stopped for a few minutes in traffic          |
| _____ |   |   |   | TOTAL   |

Yes No

- Do you suffer from nasal allergies?
- Have you had corrective nasal surgery?
- Do you take any medications that cause you to suffer from dry mouth?
- Do you sleep in a cool room? (less than 65 degrees)
- Do you sleep with the windows open year round?
- Do you feel like you have chronic nasal congestion issues?
- Are you over the age of 60?

Pharmacy: \_\_\_\_\_

YES  NO Can we contact your pharmacy to receive an electronic updated copy of your medication list?

**EMERGENCY CONTACT: *someone not in patient household***

NAME:	RELATIONSHIP:
PHONE:	ALT PHONE:

CURRENT MEDICATIONS	DOSAGE AND FREQUENCY

Medication Allergy	Reaction

CHIEF COMPLAINT - ANSWER ALL THAT APPLY	Duration (years/months)
Excessively tired throughout the day	
Gasping for air during the night	
Snoring	
Can't fall asleep at night	
Can't stay asleep at night	

Unusual behaviors during sleep  YES  NO Explain: \_\_\_\_\_

<b>SLEEP PATTERNS/ENVIRONMENT</b>	<b>Weekdays</b>	<b>Weekends</b>
Typical bedtime		
Amount of time to fall asleep		
Time up in the morning		
Average number of hours slept		
Average number of awakenings per night		
Number of bathroom trips		
Number of naps		

**SLEEP DISTURBANCES - CHECK ALL THAT APPLY**

- Pain       Snoring       Spouse       Breathing       Worrying  
 Anxiety       Pets       Children       Coughing  
 Other: \_\_\_\_\_

**PAST SLEEP EVALUATION AND TREATMENT (IF APPLICABLE)**

Last sleep evaluation:

- Less than 6 months ago       Less than 1 year ago       \_\_\_\_\_ years ago

Where \_\_\_\_\_

It included:  Overnight Sleep Study       Daytime Naps

Diagnosis: \_\_\_\_\_

- YES     NO      I use a CPAP or Bi-Level Machine  
 Pressure setting: \_\_\_\_\_ cm/H2O  
 Mask type/brand: \_\_\_\_\_  
 YES     NO      I have had surgery to treat a sleep disorder  
 Type of surgery: \_\_\_\_\_  
 YES     NO      I have been prescribed medication to treat a sleep disorder  
 Medication: \_\_\_\_\_

**PAST MEDICAL/SURGICAL HISTORY - CHECK ALL THAT APPLY**

- High Blood Pressure       Stroke       Depression       Anxiety       Asthma/Emphysema  
 Reflux       Seizures       Heart Disease       Cancer       Parkinson's Disease  
 Fibromyalgia       Lung conditions       Thyroid Conditions       Head Injury       Hearing Impairment  
 Diabetes (**note: diabetics should bring a snack to overnight sleep study appointment**)  
 History of MRSA (methicillin resistant staph aureus)

**Have you been told recently or in the past that you have MRSA, VRSA or ESBL?**     No     Yes

List any other medical problems that may disrupt your sleep


List any surgeries and the year performed


Do you use supplemental oxygen?     YES     NO                      Amount: \_\_\_\_\_ LPM  
Do you need assistance at night?     YES     NO  
Do you use a wheelchair?               YES     NO

Approximate date of last influenza vaccine: \_\_\_\_\_

If age 65 or older, approximate date of last pneumococcal vaccine: \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status:     Married     Single     Divorced     Widowed

Sleeping Arrangements:     Sleep alone    Share bed     Separate Beds

Occupation \_\_\_\_\_     Employed     Unemployed     Retired     Student

Smoking History:

Never a smoker  
 Current Smoker  
                    Cigarettes/Cigars/Tobacco \_\_\_\_\_ packs/day    for \_\_\_\_\_ years  
 Former Smoker  
                    Year quit \_\_\_\_\_    Packs/day \_\_\_\_\_ for \_\_\_\_\_ years

Alcohol Use:

Never     Daily     Weekends     Occasionally

Type of alcohol and amount: \_\_\_\_\_

Number of nights per week alcohol is used before bed \_\_\_\_\_

Caffeine use     Never     Daily     Weekends     Occasionally

Type of caffeine beverage and amount per day: \_\_\_\_\_

**FAMILY HISTORY - CIRCLE ALL THAT APPLY**

**Mother**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Father**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Sister(s)**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

**Brother(s)**    apnea    snoring    narcolepsy    insomnia    other: \_\_\_\_\_

Other \_\_\_\_\_

I have trouble falling asleep.	Never	Sometimes	Always	Unsure
I have trouble staying asleep.	Never	Sometimes	Always	Unsure
I read or watch TV in bed before falling asleep.	Never	Sometimes	Always	Unsure
I often wake up during the night.	Never	Sometimes	Always	Unsure
At bedtime, thoughts race through my mind.	Never	Sometimes	Always	Unsure
I smoke less than 2 hours before going to bed.	Never	Sometimes	Always	Unsure
I eat a snack at bedtime.	Never	Sometimes	Always	Unsure
If I wake up at night I eat a snack.	Never	Sometimes	Always	Unsure
I have nightmares.	Never	Sometimes	Always	Unsure
I sweat a lot during the night.	Never	Sometimes	Always	Unsure
I kick my legs and/or arms during the night.	Never	Sometimes	Always	Unsure
I walk in my sleep.	Never	Sometimes	Always	Unsure
I talk in my sleep.	Never	Sometimes	Always	Unsure
I grind my teeth while I sleep.	Never	Sometimes	Always	Unsure
I wake up at night choking or gasping for air.	Never	Sometimes	Always	Unsure
I wake myself up with my snoring.	Never	Sometimes	Always	Unsure
I have been told I snore while lying on my back.	Never	Sometimes	Always	Unsure
I feel my heart pounding at night.	Never	Sometimes	Always	Unsure
At bedtime I feel sad or depressed.	Never	Sometimes	Always	Unsure
I feel unable to move (paralyzed) after a nap.	Never	Sometimes	Always	Unsure
I have dream like images when I wake up even though I know I am not asleep.	Never	Sometimes	Always	Unsure
I have experienced sudden muscle weakness in response to emotions such as laughter or surprise.	Never	Sometimes	Always	Unsure
I take a nap(s) on a regular basis.	Never	Sometimes	Always	Unsure
I have fallen asleep while driving.	Never	Sometimes	Always	Unsure
I get "stuffed up" while sleeping.	Never	Sometimes	Always	Unsure
My breathing is worse when I sleep on my back.	Never	Sometimes	Always	Unsure
I get morning headaches.	Never	Sometimes	Always	Unsure
I wake up with a dry mouth.	Never	Sometimes	Always	Unsure
Pain wakes me up at night.	Never	Sometimes	Always	Unsure
I wet the bed.	Never	Sometimes	Always	Unsure
I wake up due to heartburn, reflux, a sour stomach, or burping.	Never	Sometimes	Always	Unsure