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SLEEP HISTORY / LIFE HISTORY QUESTIONNAIRE

Thank you for choosing Anderson Hospitals Center for Sleep Medicine. Our Sleep Center is managed and staffed by Board Registered Polysomnography Technologists. Every procedure performed at our Sleep Center is reviewed and interpreted by our Sleep Center Medical Director who is Board Certified in Sleep Medicine, Pulmonary Medicine, Internal Medicine, and Critical Care Medicine.

The purpose of this questionnaire is to get a total picture of your sleep and medical history which may affect the amount and/or quality of your sleep. This questionnaire and the raw data acquired during your sleep study will be reviewed by the Sleep Physician to determine your sleep diagnosis.

Please print this questionnaire and answer ALL of the questions. It is important for you to be as accurate as possible in answering them. Please complete these questions as thoroughly as you can and bring the completed questionnaire with you to your scheduled sleep appointment.

Thank you for allowing Anderson Hospital and our Center for Sleep Medicine help you in meeting all of your health care needs.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE

Date: ___/___/___ Name: _____ Age: _____ # of Children: _____

Occupation: _____ Height_____ Weight_____

1. Describe your main 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 one week
   ( ) irregularly
   ( ) other _____

3. How long has this problem bothered you?
   ( ) longer than 2 years
   ( ) 1 to 2 years
   ( ) several months
   ( ) within the last 3 months
   ( ) within the last month

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?
   ( ) 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? 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
   ( ) obstetrics/gynecology ( ) osteopath
   ( ) cardiologist ( ) nutritionist
   ( ) other internists ( ) counselor
   ( ) psychiatrist ( ) social worker
   ( ) other physician ( ) nurse
   ( ) clinical psychologist ( ) clergyman

   ( ) other: _____

9. What treatments have you received from anyone in question 8 for sleep issues?

10. Please rate how often you: (please circle the letter to the right of each statement that applies)

N: Never R: Rarely O: Occasionally F: Frequently C: Constantly

Awaken from sleep short of breath	N	R	O	F	C
Awaken at night with heartburn, belching or cough	N	R	O	F	C
Snore	N	R	O	F	C
Snore loudly enough that others complain	N	R	O	F	C
Have trouble sleeping when you have a cold	N	R	O	F	C
Suddenly wake up gasping for breath during the night	N	R	O	F	C
Have breathing problems at night (observed by self or others)	N	R	O	F	C
Sweat excessively at night	N	R	O	F	C
Notice your heart pounding or beating irregularly during the night	N	R	O	F	C
Fall asleep during the day	N	R	O	F	C
Fall asleep involuntarily	N	R	O	F	C
Fall asleep while driving	N	R	O	F	C
Fall asleep during physical effort	N	R	O	F	C
Fall asleep when laughing or crying	N	R	O	F	C
Experience loss of muscle tone when extremely emotional	N	R	O	F	C
Have trouble at school or work because of sleepiness	N	R	O	F	C
Feel unable to move (paralyzed) when waking or falling asleep	N	R	O	F	C
Experience vivid dreamlike scenes upon awakening or falling asleep	N	R	O	F	C
Feel afraid of going to sleep	N	R	O	F	C

Have nightmares	N	R	O	F	C
Remember your dreams	N	R	O	F	C
Have thoughts racing through your mind	N	R	O	F	C
Feel sad or depressed	N	R	O	F	C
Have anxiety (worry about things)	N	R	O	F	C
Have muscular tension	N	R	O	F	C
Notice parts of your body jerk	N	R	O	F	C
Kick during the night	N	R	O	F	C
Experience crawling and aching feelings in your legs	N	R	O	F	C
Experience any type of leg pain during the night	N	R	O	F	C
Have morning jaw pain	N	R	O	F	C
Grind teeth during sleep	N	R	O	F	C
Are bothered by pain during the day	N	R	O	F	C
Are awakened by pain during the night	N	R	O	F	C
Wake up feeling stiff in the morning	N	R	O	F	C
Wake up with sore or achy muscles	N	R	O	F	C
Wake up with pain in neck, spine or joints	N	R	O	F	C

11. Is your present work situation satisfactory? YES _____ NO _____

12. <u>UNDERLINE</u> any of the following that apply to you:

Headaches	Dizziness
Palpitations	Stomach trouble
Bowel disturbances	Fatigue
Nightmares	Take sedatives
Feel tense	Feel panicky
Depressed	Suicidal ideas
Unable to relax	Sexual problems
Don’t like weekends and vacations	Overambitious
Can’t make friends	Memory problems

UNDERLINE any of the following that apply to you:

Can't keep a job	Inferiority feelings
Financial problems	Fainting spells
No appetite	Insomnia
Alcoholism	Tremors
Take drugs	Shy with people
Can't make decisions	Home conditions bad
Unable to have a good time	Concentration difficulties
Take antacids regularly (Tums, Tagamet, etc.)	Others:

13. UNDERLINE any of the following words that apply to you:
Worthless, useless, a "nobody", "life is empty", inadequate, stupid, incompetent, naïve, "can't do anything right", guilty, evil, morally wrong, horrible thoughts, hostile, full of hate, anxious, agitated, cowardly, unassertive, panicky, aggressive, ugly, deformed, unattractive, repulsive, depressed, lonely, unloved, misunderstood, bored, restless, confused, unconfident, in conflict, full of regrets, worthwhile, sympathetic, intelligent, attractive, confident, considerate.

14. Does your problem disturb your sex life?

15. Is your present social life satisfactory? 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 average, how long do you stay awake? _____

21. If you do awaken during the night (after you first fall asleep), which part (s) 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 awaken in the morning 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 else in your bed
( ) sleep with someone else in your room
( ) provide assistance to someone during the night (child, bed partner, animal, etc.)

26. Is your sleep often disturbed by:

( ) heat	( ) light
( ) cold	( ) bed partner
( ) noise	( ) not being in your usual bed
( ) other _____	

27. Are your sleep habits on weekends different from the rest of the week?
( ) No
( ) Yes – please describe _____

28. With whom are you now living? (wife, husband, children, parents, etc., please list ages of children)

_____

29. Do you work split shifts or rotating (variable) shifts? _____

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 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 yes, 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. Do you take any kind of medication?
(Please list medications below or bring an updated list of your medications with you for the study.)

NAME	***AMOUNT***	***HOW OFTEN***	***REASON***

39. List your consumption of the following per day:

Cigarettes Yes _____ Packs/Day _____ Never _____ Used To _____ Months/Years Ago

Caffeine Yes _____ No _____ Quantity (beverages/day) _____

Alcohol Yes _____ No _____ Quantity (beverages/day) _____

Recreational Drugs Yes _____ No _____

How likely 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 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	Chance of Dozing
* Sitting and reading	_____
* Watching TV	_____
* Sitting, inactive in a public place (ex. Theater or 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 lunch without alcohol	_____
* In a car, while stopped for a few minutes in traffic	_____
TOTAL:	_____

MEDICAL HISTORY

Year of last full physical examination: _____

	Don't Know	Never	Rarely	Occas.	Freq'ly	Always
Snoring?	_____	_____	_____	_____	_____	_____
Breathing stops during sleep?	_____	_____	_____	_____	_____	_____
Heartburn at night?	_____	_____	_____	_____	_____	_____
Morning headaches?	_____	_____	_____	_____	_____	_____
Awake refreshed?	_____	_____	_____	_____	_____	_____
Daytime sleepiness?	_____	_____	_____	_____	_____	_____
Memory or concentration problems?	_____	_____	_____	_____	_____	_____
Job problems related to sleepiness?	_____	_____	_____	_____	_____	_____
Problems with sexual function?	_____	_____	_____	_____	_____	_____

	Don't Know	1 – 3	4 – 6	7 – 9	10 +
Number of sick days in the last 6 months?	_____	_____	_____	_____	_____
Number of doctor visits in the last 6 months?	_____	_____	_____	_____	_____
Auto accidents in the last 12 months?	_____	_____	_____	_____	_____

	Excel.	V.Good	Good	Fair	Poor
Personal assessment of current health	_____	_____	_____	_____	_____

	None	Increase	Decrease	Amount
Weight gain in last 12 months?	_____	_____	_____	_____lbs.

				Collar
Collar change in last 12 months?	_____	_____	_____inches	Size _____

	No	Yes	
High blood pressure?	_____	_____	
Heart disease?	_____	_____	If so, what: _____
Diabetes?	_____	_____	
Depression?	_____	_____	
Acid reflux?	_____	_____	
Allergies:			
Medications?	_____	_____	If so, what: _____
Seasonal?	_____	_____	If so, what: _____
Other?	_____	_____	If so, what: _____

Mental Health:

_____

(For example: depression, suicide, alcoholism)

Nervous System:

_____

(For example: strokes, seizures, diabetic nerve damage)

Ears, Eyes, Nose, Throat:

_____

(For example: nasal allergies, bronchitis, emphysema)

Breathing:

_____

(For example: asthma, bronchitis, emphysema)

Stomach:

_____

(For example: swallowing difficulties, heartburn, indigestion, hiatal hernia, ulcers)

Bowels:

_____

(For example: diarrhea, constipation, cancer)

Urinary or Kidney:

_____

(For example: infection with frequent nighttime urination or diuretics, stones, cancer)

Hormones:

_____

(For example: high or low thyroid conditions, prescribed steroids such as prednisone or estrogen for menopause)

Blood:

_____

(For example: “low blood” or anemia, thick blood, sickle cell disease, or HIV infection)

Chronic pain:

_____

(For example: arthritis, broken hip, osteoporosis)

Surgeries:

_____

(For example: tonsillectomy, adenoidectomy, nose, jaw or face surgery, hysterectomy – partial/full)

Please list any other problems or concerns, which we should know about:

_____

_____

_____

_____

_____

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_____

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