FAMILY SLEEP DIAGNOSTICS
DALLAS-FT. WORTH METROPLEX

History Questionnaire

GENERAL INFORMATION

Name: **Date:**

Referring Physician: **SS#:**

DOB: **Age:** **Sex:** ☐ **M** ☐ **F** **Height:** **"** **Weight:** **Lbs.**

Occupation: **Emergency Contact:**

*The following questions will help us understand more about you. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Please do **NOT** leave any questions unanswered. Please feel free to use the back of this page, as needed.*

Briefly describe the nature of your chief complaint:

_____

_____

_____

_____

_____

SIGNS & SYMPTOMS *(place a check by ALL of the following Signs and Symptoms which apply to you)*:

☐ Heavy Snoring	☐ Snoring interrupted by silence and then gasping	☐ Forgetfulness	☐ Shortness of Breath
☐ Grinding of the teeth	☐ Awakens with sour/bitter taste in the mouth	☐ Irritability	☐ Restless Sleep
☐ Short Temper	☐ Falling asleep at inappropriate times	☐ Fatigue/Malaise	☐ Lack of Energy
☐ Falling asleep unintentionally	☐ Excessive daytime sleepiness/ Drowsiness	☐ Morning Headaches	☐ Loss of Libido
☐ Insomnia	☐ Frequent errors or mistakes	☐ Impatience	☐ Negative Moods

About how long have you had this problem? Months Year

About how long has this problem affected your life? Months Year

MEDICAL HISTORY *(please check all that apply)*:

☐ High Blood Pressure	☐ Bypass Surgery	☐ Seasonal Allergies	☐ Nose Fracture
☐ Congestive Heart Failure	☐ Heart Attack	☐ Asthma	☐ Nasal Surgery
☐ Hiatal Hernia/Reflux	☐ Stroke	☐ Tonsillectomy	☐ Headaches
☐ COPD (emphysema, etc.)	☐ Diabetes	☐ Sinus Problems	☐ Seizures
☐ Depression and/ or Mood Disorder: _____		☐ Dementia	☐ Alzheimer's
☐ Sleep Disorder: _____		☐ Smoking: # of years: ____ Packs/day ___	
☐ Medication allergies: _____		Have you quit? ☐ Y ☐ N When? _____	

Briefly describe any serious illnesses or major medical procedures you have experienced and the year they were incurred:

Injury/ Illness/ Surgery	*Year*	*Injury/ Illness/ Surgery*	*Year*

List medications you are **currently** taking:

SLEEP HISTORY *(For the following questions, please check the response that best describes you):*

Sleep Related Question	***Never***	***Sometimes***	***Often***	***Frequently***	***Always***
Have you been told that it appears your breathing 'stops' during your sleep?	☐	☐	☐	☐	☐
Do you 'toss' & 'turn' when sleeping?	☐	☐	☐	☐	☐
Do you have difficulty falling asleep?	☐	☐	☐	☐	☐
Is it difficult for you to 'stay' asleep?	☐	☐	☐	☐	☐
Do you kick your legs or jerk during your sleep	☐	☐	☐	☐	☐
Do you experience a creeping sensation in your legs and feet at night as though you must move them?	☐	☐	☐	☐	☐
Are there times where you feel as if you must fall asleep and cannot stop it from happening (sleep attack)?	☐	☐	☐	☐	☐

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Sleep Related Question	*Never*	*Sometimes*	*Often*	*Frequently*	*Always*
Do you feel muscle weakness or have you collapsed from feeling strong emotions (laughter, scared, etc.)?	☐	☐	☐	☐	☐
Do you ever feel unable to move when waking up or falling asleep (paralyzed feeling)?	☐	☐	☐	☐	☐
Do you experience vivid, dream-like imagery when falling asleep or waking up?	☐	☐	☐	☐	☐
Do naps make you feel refreshed?	☐	☐	☐	☐	☐
Do you require special conditions to fall asleep at night?	☐	☐	☐	☐	☐
Please describe the special conditions:					
Do you drink alcohol before going to bed or during the night?	☐	☐	☐	☐	☐
When trying to sleep, do you have anxious thoughts or racing thoughts in your mind?	☐	☐	☐	☐	☐
Do you awaken with anxiousness, worry or panic?	☐	☐	☐	☐	☐
Is your sleep disturbed by a medical condition?	☐	☐	☐	☐	☐
Please describe the medical condition:					
Do you awaken because of aches or pains?	☐	☐	☐	☐	☐
Do you have trouble going back to sleep if you wake up during the night?	☐	☐	☐	☐	☐
Are you bothered by outside noises at night (i.e. planes, trains or barking dogs)?	☐	☐	☐	☐	☐
As bedtime approaches, do you become anxious?	☐	☐	☐	☐	☐
When you awaken at night, do you lie there until you fall back asleep?	☐	☐	☐	☐	☐
Do you sleep with any pets or children in the same bed?	☐	☐	☐	☐	☐

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to assess a person's daytime sleepiness. This refers to your usual way of life in recent times.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

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 in the likelihood that you would doze or sleep in each situation:

0 = ***never*** 1 = ***slight*** chance 2 = ***moderate*** chance 3 = ***high*** chance

Sitting and reading	
Watching TV	
Sitting inactive in a public place (ex: meeting, theater)	
Being a passenger in a motor vehicle for an hour or more	
Sitting and talking to someone	
Lying down to rest in the afternoon if circumstances permit	
Sitting quietly after lunch (without alcohol)	
Stopped for a few minutes in traffic while driving	
Total	