Please answer the following questions to the best of your ability. This information will help your doctor identify any sleep disorder(s) you may have. It may be helpful to ask your partner or a family member to help you complete this questionnaire. This information will be kept confidential.

- PLEASE PRINT CLEARLY-

Name: _____ Date of Birth: _____

In the space below, please describe your main sleep problem(s).

_____

_____

_____

_____

_____

Have you had a previous sleep study: YES NO When/where?

_____

Typical sleeping hours?

	Bedtime	How long does it take to fall asleep?	How many times do you awaken?	What time do you wake up and start your day?	How many hours of sleep did you get?	Are you rested?
Days where you work						
Days you don't work (vacation/weekends)						

Do you have trouble falling or staying asleep: Yes No If yes, why (unless you explained it earlier):

_____

_____

_____

Allina Health

UNITED LUNG & SLEEP CLINIC
SLEEP HISTORY QUESTIONNAIRE

59-01
Questionnaire

SR-14945 (08/17)

PATIENT LABEL

When you awaken in the night, for how long are you awake: _____

Typically, what awakens you: _____

Do you nap or doze during a typical week: Yes No How many times per week: _____ For how long: _____

On average, how much of the following do you have each day? Do you use it in the evening (after 6pm)?

Coffee (1 mug = 2 cups)	_____	cups/day	Yes
Cola/Pop/Soda (caffeinated)	_____	cups/day	Yes
Tea (caffeinated)	_____	cups/day	Yes
Energy drinks	_____	servings/day	Yes
Caffeine tablets/pills	_____	doses/day	Yes
Alcohol	_____	servings/week	Yes

Stimulants (Ritalin, Adderall, etc) (name and dose)

Prescription sleep aids (name and dose):

Over the counter sleep aid (name and dose):

Nicotine _____ cigarettes/day Yes No
(if you use something other than cigarettes like chewing tobacco, cigars, e-cigarette, explain):

Recreational drug use like marijuana? (name and frequency):

Please rate the following descriptions as they occur in your situation (check one category or each questions):

	Never	Sometimes	Frequently	Constantly
Snore	☐	☐	☐	☐
People notice you stop breathing when you sleep	☐	☐	☐	☐
You snore/snort/choke yourself awake at night	☐	☐	☐	☐
Fall asleep driving	☐	☐	☐	☐
Feel your sleepiness interferes with your ability to drive safely	☐	☐	☐	☐
Feel your sleepiness interferes with your ability to work productively	☐	☐	☐	☐
Act out your dreams (have a dream where you are in a fight, and you actually punch out/lash out?)	☐	☐	☐	☐
Walk or eat in your sleep?	☐	☐	☐	☐
Do you talk in your sleep?	☐	☐	☐	☐
A discomfort in your legs makes it difficult to fall asleep?	☐	☐	☐	☐
Grinding of your teeth?	☐	☐	☐	☐

How likely are you to doze off or fall asleep in the following situation? Consider your life in recent times.

Situation	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (theater or meeting)	0	1	2	3
Riding as a passenger in a car for more than 1 hour	0	1	2	3
Lying down to rest in the afternoon when time permits	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Brief Medical History:

	Yes		Yes
High Blood Pressure	☐	**Atrial Fibrillation/Arrythmia**	☐
COPD/Emphysema	☐	**Depression**	☐
Heart Failure	☐	**Anxiety**	☐
Coronary Artery Disease	☐	**Diabetes**	☐
ADD/ADHD	☐	**Seizure**	☐
Stroke/TIA	☐	**Tonsillectomy**	☐

Brief Family History

Are there any members of your family with sleep disorders? If so, what is your relationship and what is their diagnosis?	**Relative (i.e. mother, father)**	**Diagnosis**

Review of Systems: Check any current or chronic (long-lasting) problems.

General:
- ☐ Fever
- ☐ Chills
- ☐ Weight loss _____ #
- ☐ Weight gain_____ #
- ☐ Loss of appetite
- ☐ Unusual fatigue (tiredness) and loss of energy

Ears, Nose, Mouth, Throat:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Pain or pressure in ears
- ☐ Nasal drainage
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Morning dry mouth
- ☐ Morning sore throat

Eyes:
- ☐ Visual problems
- ☐ Tearing
- ☐ Drainage
- ☐ Other

Gastrointestinal:
- ☐ Heartburn
- ☐ Bloating

Musculoskeletal:
- ☐ Intermittent muscle weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings

Neurologic:
- ☐ Seizures
- ☐ Headaches
- ☐ Morning headaches

Genitourinary:
- ☐ Frequent night time urination

Endocrine:
- ☐ Hotter or colder than others

Allergic/Immunologic:
- ☐ Seasonal allergies

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular heart beats
- ☐ Swelling in legs

Hematology/Lymphatic:
- ☐ Anemia

Skins:
- ☐ Rashes

Pulmonary:
- ☐ Shortness of breath
- ☐ Cough