Colorado Springs Health Partners Sleep Center
1625 Medical Center Point, Suite 290
Colorado Springs, CO. 80907
Phone: (719) 866-6627 Fax: (719) 866-6629

PATIENT HISTORY QUESTIONNAIRE

Name: _____
Last First Middle

Address: _____ City/State _____ Zip _____
Pnone (home) _____ Work _____ Cell _____
SS# _____ Birth Date _____ Age: _____ ❒ Male ❒Female
Occupation: _____
Name of Family Physician: _____ Phone: _____ Fax: _____
Height: _____ Weight: _____ Weight gained in the past 2 years _____
Weight lost in the past 2 years _____

SLEEP HISTORY

Sleep Complaint _____

_____

At what age did this problem begin? _____ years old

How does this affect your life and daily activities? _____

_____

Have you had any previous evaluations, examinations or treatment for this sleep problem or any other problem with your sleep? ❒ Yes ❒ No If yes, briefly describe the evaluation, treatment and results, including medication _____

If employed, what are your usual working hours? Start time _____ Stop time _____

What time do you usually go to bed and get up on weekdays (or work days)?

_____ to bed _____ get up

What time do you usually go to bed and get up on weekends (or days off)?

_____ to bed _____ get up

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Section 1 **Insomnia**

Yes	No	
❒	❒	Do you have trouble falling asleep?
❒	❒	Are you bothered by thoughts that keep you from sleeping?
❒	❒	Are you frightened to go to sleep?
❒	❒	Do you feel depressed or sad?
❒	❒	Does it take you more than a half hour to fall asleep?
❒	❒	Do you awaken much earlier in the morning and are unable to fall back to sleep?

Section 2 **Sleep Apnea**

Yes	No	
❒	❒	Do you often feel that you get too little sleep at night?
❒	❒	Are you bothered by sleepy periods during the day?
❒	❒	Do you remember dreaming?
❒	❒	Do you snore?
❒	❒	Have you fallen asleep at the wheel of a car?
❒	❒	Are you bothered by nightmares?
❒	❒	Are you bothered by breathing problems at night?
❒	❒	Do you have unusual behavior during sleep?
❒	❒	Do you usually feel tired or sleepy during the day?
❒	❒	Do you have high blood pressure?
❒	❒	Have you been undergoing changes in your personality?
❒	❒	Do you sweat during the night?
❒	❒	Do you feel you have lost interest in sex?
❒	❒	Do you waken gasping for breath in the middle of the night?
❒	❒	Do you have headaches in the morning?
❒	❒	When you have a cold, do you find falling asleep more difficult?
❒	❒	Have you ever felt your heart pounding or beating irregularly during the night?
❒	❒	Have you been told that your job performance is not up to par?

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Section 3 **Bed Partner Questions**

Yes	No	
❒	❒	Does your bed partner snore, and are you unable to sleep due to their snoring?
❒	❒	Does your bed partner toss and turn during sleep?
❒	❒	Does your bed partner stop breathing at night?

Section 4 **Narcolepsy**

Yes	No	
❒	❒	Do you have difficulty concentrating at school or at work?
❒	❒	Do you fall asleep during the day?
❒	❒	Have you ever fallen asleep while laughing or crying?
❒	❒	Do your knees get weak if you laugh or get angry?
❒	❒	Have you fallen asleep during physical exertion?
❒	❒	During the day, do you feel dazed as if in a fog?
❒	❒	If you become angry, does your body feel limp?
❒	❒	While falling asleep or awakening, have you experienced vivid dreams?
❒	❒	Soon after falling asleep or awakening, have you had nightmares?
❒	❒	Do you often feel that you must fill your day with activity?
❒	❒	No matter how hard you try to stay awake, do you still fall asleep?

Section 5 **GERD**

Yes	No	
❒	❒	Do you gasp for breath during the night?
❒	❒	Do you awaken in the night coughing?
❒	❒	Are you hoarse in the morning?
❒	❒	Do you awaken with heartburn?
❒	❒	Do you have a chronic cough?
❒	❒	Are you taking antacids routinely on a weekly basis?
❒	❒	Do you have frequent sore throats?

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Section 6 **Restless Legs/ PLMS**

Yes	No	
❒	❒	Do you have pain that interferes with your sleep?
❒	❒	Do you awaken with muscle aches?
❒	❒	Do you have muscle tension in your legs, even outside of exercise?
❒	❒	Do you kick in bed at night?
❒	❒	Even though you sleep at night, do you awaken feeling tired?
❒	❒	Have you experienced a sensation of “crawling” or aching in your legs?
❒	❒	At night, do you feel the need to move your legs?

Section 7 **Seizure**

Yes	No	
❒	❒	Have you ever been told you have Epilepsy?
❒	❒	Have you ever had a witnessed Seizure?
❒	❒	Do you have relatives with Epilepsy?
❒	❒	Have you ever bitten your tongue or urinated on yourself at night?
❒	❒	Has your bed partner witnessed you having unusual behavior at night?

Section 8 **Parasomnia**

Yes	No	
❒	❒	Have you ever been told you sleepwalk?
❒	❒	Do you talk in your sleep?
❒	❒	Have you ever been told you wake up at night in extreme terror?
❒	❒	Do you consume food in your sleep?
❒	❒	Do you grind your teeth at night?
❒	❒	Have you ever been told you act out your dreams in your sleep?
❒	❒	Have you ever injured yourself or others during violent behavior while asleep?