Sleep Center
1625 Medical Center Point, #290
Colorado Springs, CO 80907
Phone: 1-719-866-6627 TTY **711** | Fax: 719-866-6629

Patient history questionnaire

Name: _____
Last First Middle

Address: _____ City/State: _____ Zip: _____

Phone (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

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?

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?

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?

Patient's signature _____ Date_____

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