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SLEEP HISTORY

DATE _____

PATIENT'S NAME _____

Describe your sleep complaint: _____

When and how did it begin? _____

_____

TYPICAL SLEEP HABITS

What time do you usually go to bed? _____
What time do you usually get up? _____
How many hours do you sleep in a typical night? _____

When you awaken in the morning do you feel refreshed? Yes No

When your schedule allows you to sleep as late into the morning as you wish, how many hours do you sleep? _____

Do you nap during the day? Yes No
Do you work a night or rotating shift? Yes No

LEVEL OF SLEEPINESS,

Do you feel you are more sleepy in the day than you should be? Yes No
Do you sometimes doze or fall asleep when you don't intend to? Yes No

Watching TV_____ Reading _____ During conversations _____
At meals _____ At work _____ While driving _____ Other _____

ABILITY TO OBTAIN AND MAINTAIN SLEEP

Do you often have trouble falling asleep? Yes No
Is frequent awakening during the night a problem for you? Yes No
How many times do you awaken during the typical night? _____
Do you awaken several hours early and are unable to go back to sleep? Yes No

BREATHING AND SLEEP

Have you been told that you snore? Yes No

If Yes: When did you first begin to snore? (age) _____
Has your snoring changed since it first began? Yes No
If Yes: How: _____
Rate the loudness of your snoring: Please circle

very soft very loud

1 2 3 4 5 6 7 8 9 10

Is your snoring affected by your sleeping position? Yes No
If Yes: How: _____
Have you been told that you stop breathing or have pauses in your breathing during sleep? Yes No
Does your sleeping position affect your breathing? Yes No
Do you awaken suddenly feeling short of breath or with a choking sensation? Yes No
Do you have trouble breathing through your nose? Yes No
If so, when? _____

GENERAL:

Have you had any of the following surgeries?: Tonsillectomy
Surgery of Jaws Heart Surgery Uvulopalatopharyngoplasty (UPPP)
Pacemaker Implantation Nasal Surgery Other: _____

Are you allergic to any medicine? Specify: _____
Are you on any present medication? Specify: _____