HAYWOOD
REGIONAL MEDICAL CENTER
A Duke LifePoint Hospital

Sleep Disorders Center
262 Leroy George Drive
Clyde, NC 28721
Phone: 828-452-8848
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Sleep History Questionnaire

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your bed partner may be able to assist you. This information will become part of your medical record and will remain confidential. Please fill out this entire form and bring it with you to your scheduled appointment.

Patient Name:______________________________ DOB:__________ Age:______

Address:____
Street

____
City State Zip

Phone #: Home: ______________ Cell:______________ Work: ______________

Height:______________ Weight:______________ Sex:__________

Referring Doctor:______________ Primary Care Doctor:______________

Summary of Sleep Problem:
Describe your sleep problems. For example: excessive snoring, insomnia, suspected sleep apnea, daytime drowsiness, etc.

____

____

How long have you had these sleep related problems?______________

How does this problem affect your daily activities and life in general?______________

____

____

Have you been diagnosed with sleep apnea? Yes No Are you on CPAP? Yes No If so, what pressure?__________
Are you on Oxygen? Yes No

Sleep History:

Do you snore	**Yes**	**No**
Have you been told that you quit breathing during sleep?	**Yes**	**No**
Do you wake up choking or gagging?	**Yes**	**No**
Are you drowsy during the day?	**Yes**	**No**
Do you awaken with a headache?	**Yes**	**No**
Do you awaken to go to the restroom?	**Yes**	**No**

EPWORTH SLEEPINESS SCALE

0 = NEVER 1 = SLIGHT CHANCE 2 = MODERATE CHANCE 3 = HIGH CHANCE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP WHILE……

Sitting and reading?	0	1	2	3
Watching TV?	0	1	2	3
In a theater or meeting?	0	1	2	3
Traveling as a passenger?	0	1	2	3
Resting in the afternoon?	0	1	2	3
Sitting and talking with someone?	0	1	2	3
Sitting quietly after a meal?	0	1	2	3
Sitting in a car, stopped for traffic?	0	1	2	3

TOTAL_________________

Do you have trouble falling asleep?	**Yes**	**No**
Do you wake up frequently at night?	**Yes**	**No**
Do your legs feel restless at night, like you need to move them?	**Yes**	**No**
Do your legs jerk or twitch at night?	**Yes**	**No**
Do you walk or talk in your sleep?	**Yes**	**No**
Have you had episodes of being unable to move your arms and legs while waking or going to sleep?	**Yes**	**No**
Have you had sudden episodes of weakness of the head or body brought on by laughing or strong emotion and causing your head or body to fall?	**Yes**	**No**
Do you take daytime naps?	**Yes**	**No**

What is your normal bedtime?___________________________ ______________________________

Workdays Days Off

What is your normal wake time?_________________________ ______________________________

Workdays Days Off

Approximately how many hours of sleep do you get each night?

_________________________ ______________________________

Workdays Days Off

MEDICAL HISTORY

Medication:

Please list ALL medications. Provide name and amount taken.

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Allergies:____

MEDICAL ILLNESSES
Do you have a history of any of the following**:**

HYPERTENSION (High blood pressure)	**YES**	**NO**
MYOCARDIAL INFARCTION (Heart attack)	**YES**	**NO**
STROKE	**YES**	**NO**
CONGESTIVE HEART FAILURE	**YES**	**NO**
OBESITY OR OVERWEIGHT	**YES**	**NO**
MOTOR VEHICLE ACCIDENTS	**YES**	**NO**
COPD	**YES**	**NO**

OTHER MEDICAL ILLNESSES ____
____
____
____

What operations have you had? ____
____
____

Do you have a family history of sleep disorders? **YES** **NO**

Do you smoke cigarettes	**YES**	**NO**	How much?____________________________
Are you a former smoker?	**YES**	**NO**	When did you quit?_____________________
Do you drink alcohol?	**YES**	**NO**	How much?____________________________

REVIEW OF SYSTEMS: HAVE YOU RECENTLY HAD (circle any of these which apply)

Constitutional: Fever, night sweats, weight gain, weight loss, exercise intolerance

Eyes: Dry eyes, change in vision, eye irritation

Ears, nose and throat: Difficulty hearing, ear pain, nose problems, sinus problems, sore throat, snoring, dry mouth, mouth ulcers

Cardiovascular: Chest pain, arm pain on exertion, shortness of breath when walking, shortness of breath when lying down

Respiratory: cough wheezing, shortness of breath, coughing up blood

Gastrointestinal: Abdominal pain, vomiting, change in appetite, diarrhea, vomiting blood, indigestion, GERD

Genitourinary: difficulty urinating, blood in the urine, urinary frequency

Musculoskeletal: Muscle aches, muscle weakness, joint pain, back pain, swelling of the extremities

Skin: Rash, itching, dry skin, skin lesion

Neurologic: weakness, numbness, seizures, dizziness, migraines, headaches

Psychiatric: Depression, sleep disturbance, alcohol abuse, anxiety, suicidal thoughts

Endocrine: fatigue, increased thirst, hair loss, cold intolerance

Hematologic/lymphatic: Swollen glands, bruising, excessive bleeding

Allergic/immunologic: runny nose, sinus pressure, itching, hives