Baylor Scott & White Neurology - Plano

Adult Sleep History Questionnaire

4708 Alliance Blvd. Suite 550, Plano, TX 75093

Please answer these questions to help us understand your sleep problem. If possible, get help from someone who has seen you sleep (spouse, bed partner, friend, family) to answer these questions.

Patient Name: _____ Date of appointment: _____

What is the REASON FOR YOUR VIIST?

_____

_____

On typical WEEKDAYS or WORKDAYS:
My bed time is _____ ☐ PM ☐ AM
It takes me _____ ☐ min ☐ hours to fall asleep
My FINAL wake up time is _____ ☐ PM ☐ AM
Do you wake up feeling rested? _____ ☐ Yes ☐ No

On typical WEEKDENDS or DAYS OFF:
My bed time is _____ ☐ PM ☐ AM
It takes me _____ ☐ min ☐ hours to fall asleep
My FINAL wake up time is _____ ☐ PM ☐ AM
Do you wake up feeling rested? _____ ☐ Yes ☐ No

PLEASE CHECK 'YES' OR 'NO' AND FILL IN THE BLANKS:

☐ YES ☐ NO **My bed times vary**. If yes, please explain: _____
☐ YES ☐ NO **My morning wake up times vary**. If yes, please explain: _____
☐ YES ☐ NO **Do you take naps during the day?**
If YES: How many naps do you usually take per day? _____
How long is your usual nap? _____ ☐ min ☐ hours
Do you wake up feeling rested? ☐ YES ☐ NO
☐ YES ☐ NO **Do you wake up during the night?**
If YES: How many times do you USUALLY wake up? _____
How long do you USUALLY stay awake? _____ ☐ min ☐ hours
What wakes you up? _____
☐ YES ☐ NO **Do you work shifts?** If YES: Please describe your work schedule

_____

_____

☐ YES ☐ NO **Do you drink any beverages containing CAFFEINE?**
If YES: Please give more details about HOW MUCH and HOW OFTEN
Coffee: _____
Hot Tea: _____
Iced Tea: _____
Caffeinated soda (including Mountain Dew, Dr. Pepper, Code, Pepsi, diet soda, and energy drinks):
_____

☐ YES ☐ NO **Do you drink any beverages containing ALCOHOL?**
If YES: Please give more details about HOW MUCH and HOW OFTEN
Beer: _____
Wine: _____
Liquor: _____

Baylor Scott & White NEUROLOGY PLANO

☐ YES ☐ NO **Have you ever felt you should CUT DOWN on your drinking?**
☐ YES ☐ NO **Have people ANNOYED you by criticizing your drinking?**
☐ YES ☐ NO **Have you ever FELT BAD or FELT GUILTY about your drinking?**
☐ YES ☐ NO **Have you ever had an EYE OPENER (a drink first thing in the morning) to steady your nerves or get rid of a hangover?**

RATE HOW SLEEPY YOU FEEL DURING THE DAY

How likely are your to DOZE OFF (not just feeling tired or fatigued) in the following situations?
This refers to how sleepy you feel RECENTLY (such as the last TWO WEEKS).
If you have not felt these things recently, try to IMAGINE how sleepy you would feel in these situations.
Use the following scale to choose (CIRCLE) the most appropriate number in each situation.

0 = I would NEVER doze off
1 = I would have a SLIGHT CHANCE of dozing off
2 = I would have a MODERATE CHANCE of dozing off
3 = I would have a HIGH CHANCE of dozing off

Chance of Dozing				
0	1	2	3	Sitting and reading
0	1	2	3	Watching TX
0	1	2	3	Sitting, inactive in a public place (such as a theater, meeting, classroom, or church)
0	1	2	3	As a passenger in a car for an hour without a break
0	1	2	3	Lying down for a rest in the afternoon when circumstances permit
0	1	2	3	Sitting and talking to someone
0	1	2	3	Sitting quietly after a lunch without alcohol
0	1	2	3	In a car, while stopped for a few minutes in traffic (while at the wheel)

What do you do for exercise?

_____

_____

What was your approximate weight 1 year ago_____ pounds
5 years ago _____ pounds

☐ YES ☐ NO **Do you currently use products containing TOBACCO?**
If YES: Please give us more details about HOW MUCH and HOW OFTEN
Cigarettes: _____
Cigar: _____
Pipe: _____
Chewing Tobacco: _____
☐ YES ☐ NO **If you used tobacco in the past, HOW MUCH and for HOW LONG?** _____
When did you quit? _____
☐ YES ☐ NO **Have you ever regularly used "recreational" or illegal drugs?**
If YES: Please give us more details about HOW MUCH and HOW OFTEN
Drug: _____ How much: _____ How often: _____
Drug: _____ How much: _____ How often: _____
Drug: _____ How much: _____ How often: _____
☐ YES ☐ NO Are you still using any of the above? _____

Do you use any of the following within FOUR HOURS of BEDTIME?
☐ CAFFEINE ☐ TOBACCO ☐ ALCOHOL ☐ RECREATIONAL DRUGS

How well do you sleep outside of your bedroom in your home (such as on a couch or recliner)?
☐ WORSE ☐ SAME ☐ BETTER
How well do you sleep outside of your home?
☐ WORSE ☐ SAME ☐ BETTER

☐ YES ☐ NO **Do you frequently check the time when you are having trouble falling asleep?**
If YES: How does it make you feel to the time when you are not sleeping?

_____

☐ YES ☐ NO **Are you anxious or afraid when you get into bed to sleep?**
If YES: Please explain why you feel anxious or afraid.

_____

☐ YES ☐ NO **Do you have uncomfortable (not painful) feelings in your legs?**
If YES: Please describe the feelings in your legs. _____
Is it worse at night? _____
What makes it better? _____
How do these feelings in your legs affect your sleep?

_____

Do you HAVE or USE at night? ☐ Oxygen
☐ CPAP or BPAP (bilevel)
☐ Bite guard

Do you have any of the following symptoms? If yes, please check the box:
☐ Snoring
☐ Wake up gasping for breath or choking
☐ Stop breathing during sleep
☐ Restless sleep
☐ Sweat excessively while asleep
☐ Ever wet the bed while asleep
☐ Cannot sleep on your back
☐ Becomes short of breath lying down
☐ Wake up with heartburn or a sour, stomach-acid taste (acid reflux or indigestion)
☐ Wake up with a sore throat
☐ Wake up with my heart beating fast or missing beats
☐ Wake up confused and disoriented
☐ Often have a headache when you wake up
☐ Often wake up with nausea or wanting to vomit
☐ Often have dry mouth when you wake up
☐ Often have difficulty falling asleep due to shortness of breath or coughing
☐ Often have difficulty falling asleep dur to sadness or depression
☐ Often have difficulty falling asleep due to being anxious or afraid

☐ Often have difficulty falling asleep dur to racing thoughts
☐ Often have difficulty falling asleep due to pain
☐ Grind your teeth while asleep
☐ Feel paralyzed when going to sleep or when waking up
☐ Dream-like visions (hallucinations) even though you know you are awake
☐ "Act out" your dreams
☐ Frequent nightmares
☐ Frequently sleepwalk
☐ Frequently talk in your sleep
☐ Cannot keep your legs still prior to falling asleep
☐ Irresistible need to move your legs with lying down or sitting
☐ Difficulty driving short distances because of sleepiness
☐ Difficulty driving long distances because of sleepiness
☐ Problems with relationships or social interactions because of sleepiness
☐ Problems with work or education because of sleepiness
☐ Problems with concentration and memory because of sleepiness
☐ Problems with falling down because of sleepiness
☐ Feel depressed
☐ Feel anxious or nervous
☐ History of physical or emotional trauma
☐ Claustrophobia
☐ Erectile dysfunction
☐ Often have sudden weakness (not dizziness) in the knees, neck or arms when you are startled, laughing, angry, or emotional
☐ Difficulty controlling your blood pressure
☐ Difficulty controlling your diabetes/blood sugar
☐ Swelling on your feet or ankles

Do you HAVE NOW or have you EVER HAD (check all that apply):

☐ Acid reflux (GERD)	☐ Chronic pain	☐ Heart failure	☐ Obesity
☐ Alcoholism	☐ Coronary artery disease	☐ Heart murmur	☐ Parkinson's Disease
☐ Allergies	☐ Dentures	☐ Heart surgery	☐ Pneumonia
☐ Alzheimer's Disease	☐ Depression	☐ Hepatitis	☐ Schizophrenia
☐ Anemia	☐ Diabetes	☐ High blood pressure	☐ Seizures/Epilepsy
☐ Angina	☐ Drug abuse	☐ High cholesterol	☐ Sinus problems
☐ Anxiety	☐ Emphysema/COPD	☐ HIV	☐ Stroke
☐ Arthritis	☐ Erectile dysfunction	☐ Injury to nose	☐ Thyroid disease
☐ Asthma	☐ Fibromyalgia	☐ Kidney disease	☐ Tonsilitis
☐ Cancer	☐ Heart attack	☐ Mental illness	☐ Tuberculosis

Please list ANY OTHER MEDICAL PROBLEMS not mentioned above:

_____
_____
_____
_____
_____

Do you have any BLOOD RELATIVES who have or had (check all that apply):

☐ Alcoholism	☐ Depression	☐ High cholesterol	☐ Restless Legs Syndrome
☐ Alzheimer's Disease	☐ Diabetes	☐ Insomnia	☐ Schizophrenia
☐ Allergies	☐ Drug abuse	☐ Kidney disease	☐ SIDA or Crib Death
☐ Anemia	☐ Emphysema/COPD	☐ Loud snoring	☐ Sleep apnea
☐ Anxiety	☐ Epilepsy/seizures	☐ Mental illness	☐ Sleepwalking
☐ Asthma	☐ Excessive sleepiness	☐ Narcolepsy	☐ Stroke
☐ Cancer	☐ Heart disease	☐ Obesity	☐ Thyroid disease
☐ Coronary artery disease	☐ High blood pressure	☐ Parkinson's Disease	☐ Tuberculosis

Please list any other significant MEDICAL CONDITIONS that RUN IN THE FAMILY:

_____

_____

_____

I am: ☐ Single ☐ Married ☐ Committed relationship ☐ Widowed

I live: ☐ Alone ☐ With (describe relationship): _____

I am ☐ Working ☐ On disability ☐ Retired ☐ Other: _____

My occupation is/was: _____

The highest level of education I have completed is: ☐ Highschool ☐ College ☐ Post-graduate ☐ Other