Sandhills NEUROLOGISTS
dTMS • SLEEP • BALANCE

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Sleep History Questionnaire

PATIENT INFORMATION

Name (Last, First, MI)	Today's Date:
Referring Physician:	Primary Care Physician:
Weight: _____Lbs	Height: _____Feet _____Inches

SLEEP PROBLEMS (please check all that apply)

☐ Snoring
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Tired/sleepy during the day
☐ Gasping / choking / repeated pauses in breathing while sleeping
☐ Unusual behavior(s) during sleep (walking, talking, etc.)
☐ Morning headache
☐ Other _____

GENERAL HABITS

1. Please describe your predominant work schedule: ☐Unemployed/Retired ☐Variable Schedule
   ☐Day shift (9am-5pm) ☐Evening shift (3pm-11pm) ☐Night shift (11pm-7am)

2. How many cups of caffeinated beverages do you drink per day? ☐None ☐3-5 cups
   ☐1-2 cups ☐6 cups or more

3. When do you usually drink your last cup of caffeinated beverage each day?
   ☐Before noon ☐Before 8pm ☐Before 4pm ☐Within 1 hour of bedtime

4. Do you smoke cigarettes? ☐Yes ☐No
   a) If yes, how many packs do you smoke per day?
   ☐Less than ½ pack ☐1/2 pack ☐1pack ☐2 packs or more

5. How many alcoholic beverages do you have each week on average?
   ☐None ☐1-7 drinks ☐8-14 drinks ☐15 or more drinks

6. How many days per week do you exercise 30 minutes or more?
   ☐0 days ☐1-2 days ☐3-4 days ☐5-7 days

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SLEEP HABITS	**Work Day**	**Non-Work Day**
1. What time do you go to bed?	☐am ☐pm	☐am ☐pm
2. What time do you turn off the lights to go to sleep?	☐am ☐pm	☐am ☐pm
3. What time do you get out of bed to start the day?	☐am ☐pm	☐am ☐pm
4. How many hours do you actually spend in bed?		
5. How many hours do you think you actually sleep?		

6. How many days per week do you nap? ☐0 days ☐1-2 days ☐3-6 days ☐Daily
   a) If you do nap, for how long? _____Hours_____Minutes
7. Do you have a bed partner who can observe you sleep? ☐Regularly ☐Sometimes ☐Rarely ☐ Never
8. Do you do any of the following activities in bed? ☐Read ☐Watch TV ☐Worry ☐Have arguments

PREPARING FOR SLEEP

1. On average, how long does it take you to fall asleep at night?
   ☐Less than 5 minutes ☐5-30 minutes ☐30 minutes to an hour ☐1-2 hours ☐More than 2 hours
2. If it takes you more than 30 minutes to fall asleep, please indicate when this started:
   ☐Less than 3 months ago ☐3 months to a year ago ☐More than a year ago
3. How often do you use medication or alcohol to help you fall asleep?
   ☐Never ☐1-2 times a month ☐3-5 times a week ☐1-2 times a week ☐Every night
   If you use medication, what type do you use?

LEG MOVEMENTS

1. Do you have a strong urge to move your legs while sitting or lying down? ***If NO, skip to the next section*** ☐Yes ☐No
2. Is the sensation worse when you are sitting/lying down than when you are moving around or walking? ☐Yes ☐No
3. Does the sensation improve if you get up, stretch your legs or walk? ☐Yes ☐No
4. Is the sensation worse in the evening/night than in the morning/afternoon? ☐Yes ☐No
5. How often does this sensation occur? ☐2-3 times per week ☐4-5 times a week ☐6-7 times a week ☐2-4 times per month
6. Does this sensation interfere with your sleep? ☐Yes ☐No

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DURING SLEEP

1. *Has anyone ever told you that you:*	Frequently	Occasionally	Never	Don't Know
a) Snore?				
b) Stop breathing or wake up gasping for air?				
c) Grind your teeth during sleep?				
d) Sleepwalk, wake up screaming or eat while asleep?				
e) Kick or twitch your legs during sleep?				
f) Act out your dreams?				

2. How often do you wake up in the middle of the night? ☐Frequently ☐Occasionally ☐Never ☐Don't Know
3. If you wake up, what awakens you?
4. What do you do when you are awake?
5. How long do you stay awake after you are awakened?

AWAKE

1. How do you feel when you wake up in the morning?
   a) Tired (want to continue sleeping) ☐Always ☐Often ☐Rarely ☐Never
   b) Suffer from pain or stiffness ☐Always ☐Often ☐Rarely ☐Never
   c) Sore throat or dry mouth ☐Always ☐Often ☐Rarely ☐Never
   d) Headache ☐Always ☐Often ☐Rarely ☐Never
2. How often does your sleep problem interfere with your work/home functioning (daily chores, concentration, memory, driving, etc)? ☐Always ☐Often ☐Rarely ☐Never
3. As a result of sleepiness, have you experienced any of the following:
   ☐Auto accident ☐Poor work performance or work related injury ☐Reduction in quality of life ☐None of these
4. Have you ever been paralyzed (unable to move all of your muscles) for a short time when you first awaken? ☐Yes ☐No
5. When you are laughing, surprised or angry, do you muscles become weak (jaw drooping, leg buckling or falling down)? ☐Yes ☐No

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6. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you ***CHOOSE THE MOST APPROPRIATE ANSWER FOR EACH OF THE FOLLOWINS SITUATIONS:***	High chance of dozing	Moderate chance of dozing	Slight chance of dozing	Would never Doze
a) Sitting and reading				
b) Watching TV				
c) As a passenger in a car for an hour without a break				
d) Sitting inactive in a public place (theater, meeting)				
e) Lying down to rest in the afternoon when circumstances permit				
f) In a car while stopped for a few minutes in traffic				
g) Sitting quietly after lunch without alcohol				

HEALTH

1. Which of these sleep disorders have you ever been diagnosed with or treated for? ☐ Obstructive Sleep Apnea ☐ Central Sleep Apnea ☐ Insomnia ☐ Narcolepsy ☐ Restless Leg Syndrome ☐ Periodic Limb Movement Disorder ☐ Other _____

2. If you have been diagnosed and treated for Sleep Apnea, which treatment do you use? *Check all that apply*
   ☐CPAP ☐Surgery ☐Dental Appliance ☐Other_____

3. Have you or any of your immediate family members been diagnosed or treated for any of these sleep disorders? *Check all that apply*
   ☐ Central Sleep Apnea ☐ Insomnia ☐ Narcolepsy ☐ Restless Leg Syndrome ☐ Periodic Limb Movement Disorder ☐ Other _____

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4. Have you ever had any trauma or surgery on your upper airway?(tonsillectomy, sinus operation, etc) □Yes □No

   If Yes, please explain:_____

5. Has your weight fluctuated much over the last year? □Weight loss of 10+ pounds □Weight gain of 10+ pounds

6. Have you ever been diagnosed with any of the following?

Please check all that apply

☐Allergies/Nasal Congestion/Sinusitis	☐High Cholesterol	☐Stroke	☐Depression	☐Emphysema/COPD
☐Congestive Heart Failure	☐Migraine Headaches	☐Diabetes	☐Atrial Fibrillation	☐Heart Valve Problem
☐Heart Disease(Angina/Heart Attack)	☐Seizures/Epilepsy	☐Anxiety	☐High Blood Pressure	☐Irregular Heart Beat
☐Swallowing problems	☐Down's Syndrome	☐Arthritis	☐Hyperthyroidism	☐Hypothyroidism
☐Panic Disorder	☐Brain Injury	☐Arthritis	☐Schizophrenia	☐Kidney Disease
☐Arthritis	☐Liver Disease	☐Asthma		

7. Please list all other medical conditions you currently have:_____

_____

_____

_____

8. Please list all medications and the dose you are currently taking:_____

_____

_____

_____