Sleep Disorder Center
History Questionnaire

Part I: General Information

Date: _____

Name: _____ Gender: Male _____ Female _____

Address: _____

Home Telephone #: ( ) _____ Work/Other Telephone #: ( ) _____

Date of Birth: _____ Age: _____ Marital Status: _____ Height: _____

What is (or was) your weight:

A. Now _____ lbs
B. When age 20 _____ lbs
C. When heaviest _____ lbs

Occupation: _____ Social Security #: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Telephone #: ( ) _____ Work/Other #: ( ) _____

Part II: Sleep History

1. Please describe your reason for having this sleep study:

   _____

   _____

   How long have you had this problem? _____

2. How many times do you wake up during the night:
   A. On an average night _____ B. On a bad night _____

3. Estimate how many hours of sleep you get:
   A. On an average night _____ B. On a bad night _____

4. How long does it take you to fall asleep:
   A. On an average night _____ B. On a bad night _____

5. Has anyone told you that you snore loudly? Yes _____ No _____

   If yes, has your snoring caused people to refuse to sleep in the same room? Yes _____ No _____

6. Please indicate if you have noticed (or someone has told you) that you:
   A. Suddenly wake up gasping for breath or short of breath Yes _____ No _____

   B. Wake up with a morning headache Yes _____ No _____

   C. Snort yourself awake Yes _____ No _____

   D. Notice your legs jerking or twitching during the night Yes _____ No _____

   E. Are unable to move when falling asleep or immediately upon waking Yes _____ No _____

   F. Have episodes of sudden muscular weakness (Paralysis or inability to move) when laughing, angry, or other emotional distress Yes _____ No _____

   G. Wake up confused and wander during the night Yes _____ No _____

   H. Have nightmares Yes _____ No _____

Part III. Daytime Functioning

How likely are you to doze of or fall asleep in the following situations, in contrasts to just feeling tired? This refers to your usual way of life recently. Even if you have not done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Epworth Sleepiness Scale (ESS)

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

	Chance of Dozing
Sitting and reading (Not in bed)	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a movie theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
As the driver of a car while stopped for traffic	_____

1. Do you have a problem with severe sleepiness (feeling very sleepy or struggling to stay awake) during the daytime? Yes _____ No _____

2. Do you often have a problem with your performance at work because of sleepiness? Yes _____ No _____

3. Have you ever had a car accident caused by your sleepiness (Not due to drugs or alcohol)? Yes _____ No _____

4. Have you ever had a near car accident (e.g. driving off the road) because of sleepiness (Not due to drugs or alcohol)? Yes _____ No _____

   If yes, how many times? _____

5. Do you fall asleep without meaning to during the day? Yes _____ No _____

6. At what time of the day do you feel the most fatigued/sleepy? _____

Part IV: Sleep Habits

1. On average, what is your normal bedtime? _____
   On average, what time do you get out of bed in the morning? _____

2. How many naps do you take during the average week? _____
   How long is your average nap? _____

3. How many nights during the week do you lie in bed for at least 30 minutes either trying to fall asleep or trying to return to sleep? _____

4. Does your job require that you change shifts? Yes _____ No _____
   If yes, please describe: _____

5. How much of the following do you consume during the average day?

   A. Alcohol _____
   B. Coffee (with caffeine) _____
   C. Tea (with caffeine) _____
   D. Soft drinks (with caffeine) _____
   E. Cigarettes _____
   F. Other tobacco products _____

Part V: Medical History

Please check if you have ever had any if the following conditions:

_____ Allergies
_____ Arthritis
_____ Asthma
_____ Chronic Pain
_____ Depression
_____ Diabetes
_____ Difficulties with memory or concentration
_____ Emphysema
_____ Epilepsy or Seizures
_____ Frequent headaches
_____ Hallucinations or Delusions
_____ Heart Problems
_____ Hiatal Hernia
_____ High blood pressure
_____ Kidney problems
_____ Nose or throat problems
_____ Panic attacks
_____ Problems with alcohol or drugs
_____ Severe anxiety or nervousness
_____ Stroke
_____ Sexual function problems
_____ Thyroid problems
_____ Trouble breathing at night
_____ Ulcer/heartburn

Have you ever had any of the following? :

1. Your tonsils or adenoids removed? Yes _____ No _____
2. Any nose surgery? Yes _____ No _____
3. A broken nose? Yes _____ No _____
4. A broken jaw? Yes _____ No _____
5. Any jaw surgery? Yes _____ No _____
6. Told that your teeth don't line up properly? Yes _____ No _____

Please list all medications you are now taking:

_____

_____

_____

_____

_____

Part VI: Other Information

Please add any other information that you feel is important.

_____

_____

_____

_____

_____

May we have permission to release this information and the results of the sleep study to your physician and to any agency that your physician may consult about treatment? Yes _____ No _____

_____ _____
Patient's Signature Date Signed

Sleep Diary

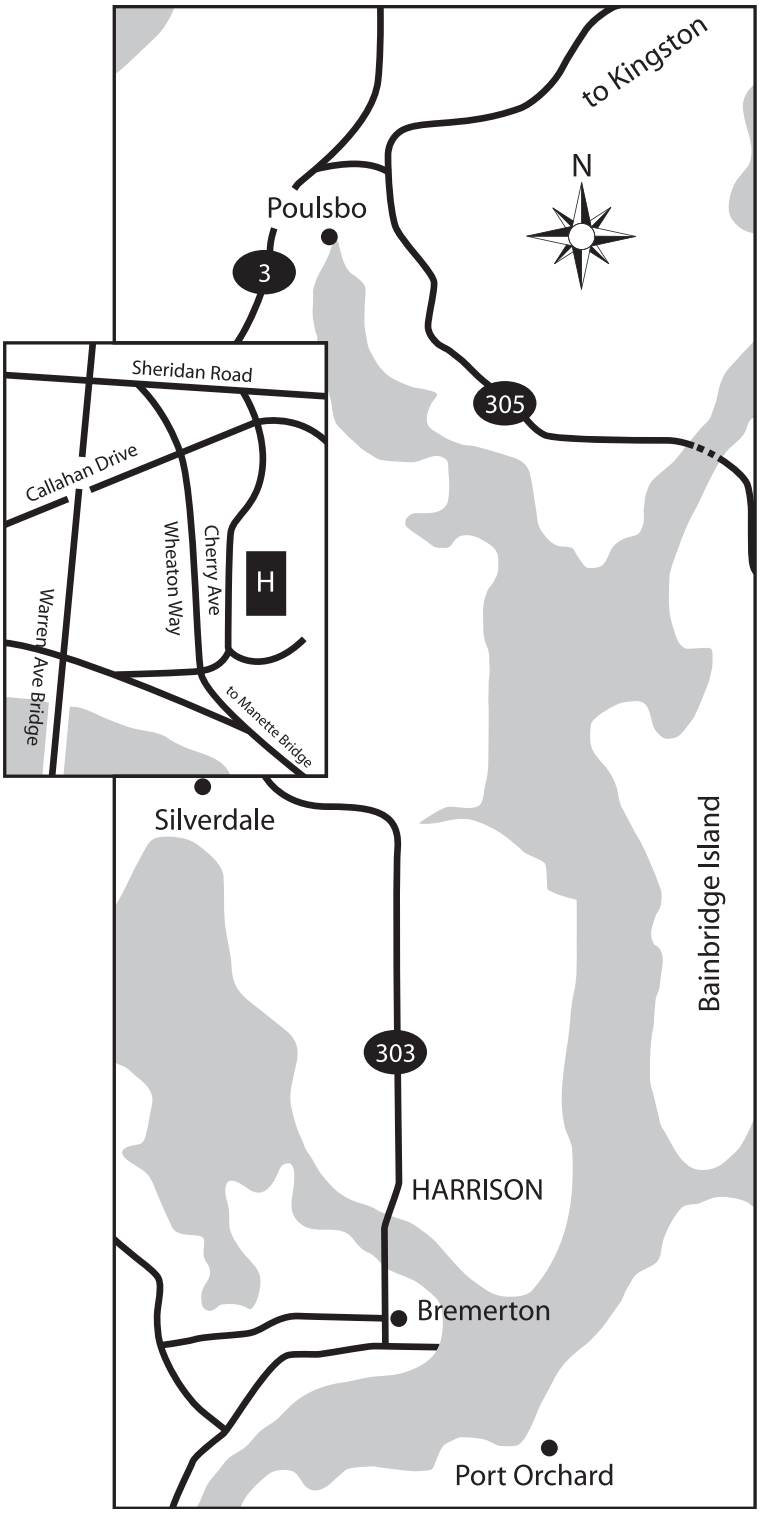
Name: _____ Date of study: _____

Please start filling out the sleep diary two (2) weeks prior to your scheduled appointment and bring completed diary with you to your sleep study.

	Date	Time to Bed	Time Up	Number of Nighttime Awakening	Total Hours of Sleep	How Many Naps Taken & Time	Sleep Med., Type, When Taken	Caffeine or Alcohol & Time
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Patient Label Here

Map to Harrison Medical Center - Sleep Disorder Center



Directions to the Sleep Disorder Center: The Sleep Disorder Center is located on the third floor of Harrison Medical Center in Bremerton. The easiest access is to come through the Main Entrance of the hospital. Come to the Information Desk in the Main Lobby and ask for directions to the Sleep Center.

You will be directed down the corridor to Elevator B. Please go to the third floor. Step off the elevator and directly across the hall is the Sleep Center Waiting room.