SLEEP HISTORY QUESTIONNAIRE

(TO BE COMPLETED BY PATIENT)

Name: ________________________________Social security number: _____________________ Date: ___________

ATTENTION PATIENTS:

The physicians of Southeastern Lung Care specializes in both pulmonary medicine and sleep medicine. This questionnaire asks general questions relating to your sleep and will help us determine if you may have some kind of sleep disorder. The symptoms of some sleep disorders are obvious, like snoring, while others may be more subtle. We appreciate your assistance in helping us to provide you with the best and most complete care possible by filling out this form completely and honestly.

SYMPTOMS DURING SLEEP

Indicate by PLACING A CHECK MARK if you experience any of the following symptoms when sleeping or trying to sleep:

__Loud snoring
__Breathing or snoring stops in my sleep
__Awaken gasping for breath
__Become sleepy during the day
__Difficulty falling asleep
__Difficulty remaining asleep
__Fatigue
__Awaken with a dry mouth
__Morning headaches
__Irritability/ Depression
__Memory impairment or Inability to concentrate
__Irresistible urge to move legs or arms
__Legs or arms jerking during sleep
__Frequent urination disrupting sleep
__Sleep talking or Sleep walking

Have you previously been diagnosed with a sleep disorder? _______

If yes, when and what disorder? ______________________
____
____

SLEEP HABITS

1) At what time do you usually get in the bed?______AM/PM
2) How long does it take you to fall asleep after you have turned out the lights _________minutes/hours
3) How often do you awaken each night ___________
4) Total time I spend awake in bed _______minutes/hours
5) I usually wake up from sleep at______________AM/PM
6) What time do you get out of bed from sleep____AM/PM
7) Indicate total length of naps daily_____________
8) If you do rotating shift work, or have other work schedule changes and need more space to describe:_______________

WEIGHT HISTORY

What do you weigh now?________
What was your weight? 1 yr ago _______ 5 yrs ago _______
Any changes in collar size? 1 yr ago _____ 5 yrs ago ______

SOCIAL HISTORY

Do you smoke? ____ Did you previously smoke? ______
# of yrs of smoking? _____ How much per day?_________

Do you drink alcohol?
How much? __________ drinks per (day/week/month)
How many caffeinated beverages do you drink daily? ______

FAMILY HISTORY (Check all that apply)

Is there a family history of:

	Mother	Father	Brother	Sister	Grand-parent
Apnea					
Snoring					
Narcolepsy					
Insomnia					
Restless Legs Syndrome					
Other sleep disturbance					

If these symptoms are bothering you, tell your doctor and feel free to contact:

Southeastern Lung Care and The Sleep Disorders Centers

Decatur Office (404) 294-4018 Rockdale Office (770) 922-2217

Winn Way Office (404) 508-6257 Johns Creek Office (678) 474-9277

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