Memorial Hospital
Belleville, Illinois 62226

SLEEP HISTORY QUESTIONNAIRE

Please fill out this questionnaire and bring it with you to your scheduled appointment. Thank you.

Name: _____ D.O.B.: _____ Sex: M F Marital Status: _____

Height: _____ Allergies to Medicines: _____

Sleep Habits

1. What is your normal bedtime? _____ AM _____PM
2. What time do you usually wake up? _____ AM _____PM
3. How long does it usually take you to fall asleep? _____
4. How many times during your sleep do you wake up? _____
5. Do you usually only wake up to use the restroom? _____
6. How many naps do you take in a typical week? _____ For how long? _____

Sleep Problems

In your own words, briefly describe your sleep-related problem: _____

_____

_____

	YES	NO
1. Do you sleep with someone in your bed?	☐	☐
2. Does your bed partner complain about you snoring?	☐	☐
3. Does your bed partner ever report that you stop breathing while sleeping?	☐	☐
4. Does your snoring awaken you while sleeping?	☐	☐
5. Do you ever feel unpleasant sensations in your legs? (crawling feeling, aching, pain, urge to move a lot)	☐	☐
6. Are you often very tired during the day?	☐	☐

When Falling Asleep How Often Do You:

	Never	Sometimes	Often
1. Suddenly wake up gasping for breath?	___	___	___
2. Wake up with a very dry mouth?	___	___	___
3. Have difficulty falling asleep?	___	___	___
4. Have difficulty staying asleep?	___	___	___
5. Do you fall asleep at unwanted times?	___	___	___
6. Depend on an alarm to wake up?	___	___	___
7. Sleep an hour past your normal wake up time?	___	___	___
8. Have restless, disturbed sleep?	___	___	___
9. Feel your heart racing at night?	___	___	___
10. Sweat during your sleep?	___	___	___
11. Walk in your sleep?	___	___	___
12. Wake up violent or confused?	___	___	___
13. Have nightmares?	___	___	___
14. Wet the bed?	___	___	___
15. Wake up with a headache?	___	___	___
16. Wake up sick to your stomach?	___	___	___
17. Wake up with jaw pain?	___	___	___
18. Grind your teeth while sleeping?	___	___	___
19. Do you have anxiety or disturbing thoughts?	___	___	___
20. Do you feel weakness in your muscles when laughing, surprised or excited?	___	___	___

Do not write below this line

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SLEEP HISTORY QUESTIONNAIRE
CM684-004 R07/07

Please List All of Your Current Medications and Dosages:

_____

_____

_____

_____

_____

Health History	**Yes**	**No**
1. Have you ever been diagnosed with a sleep disorder?	☐	☐
2. Have you ever had your tonsils or adenoids removed?	☐	☐
3. Does anyone in your family have a sleep disorder?	☐	☐

Please check any of these illnesses that you have or have had in the past:

☐ Heart Disease	☐ Seizures	☐ Nasal Congestion	☐ Impotence
☐ High Blood Pressure	☐ Diabetes	☐ Prostate Problems	☐ Bladder Trouble
☐ Low Blood Pressure	☐ Asthma	☐ Mental Problems	☐ Depression
☐ Abnormal Thyroid	☐ Hearing Trouble	☐ Fainting	
☐ Congestive Heart Failure	☐ Cancer	☐ Emphysema	

Please list any surgeries that you have had: _____

_____

_____

General History	**Yes**	**No**	
1. Do you smoke cigarettes?	☐	☐	If yes, how many packs per day?_____How many years? _____
2. Do you exercise?	☐	☐	If yes, how often?_____
3. Do you drink alcohol?	☐	☐	If yes, how much per day? _____
4. Do you drink caffeine?	☐	☐	If yes, how much per day? _____
5. Do you use over the counter sleeping pills to help you sleep?	☐	☐	If so, what kind?_____
6. Does your sleep problem interfere with work or school?	☐	☐	
7. What is your occupation? _____			
8. What are your normal work/school hours? _____			

If it become necessary, is there any family or friends that we may share your health information with, other than healthcare providers participating in your care?

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Do you have a Living Will? ☐ **Yes** ☐ **No** **If not, would you like information on obtaining one?** ☐ **Yes** ☐ **No**

Do not write below this line.

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