REM DIAGNOSTICS
Specialists in Sleep Diagnostics
SLEEP HISTORY QUESTIONNAIRE

Name: _____ Age:_____ Ht:_____ Wt:_____

Usual sleep habits:
Bed time: _____ Number of times awake to urinate, etc:_____
Wake time:_____ Number of naps per week: _____ Neck collar size: _____

Check statements which apply:
_____ Tiredness
_____ Non rested upon awakening
_____ Daytime sleepiness
_____ Choking sensation
_____ Fall asleep at inappropriate times
_____ Very loud snorer
_____ Restless sleep
_____ Late sleeper
_____ Trouble with concentration
_____ Light sleeper
_____ Stop breathing during sleep
_____ Awaken with headache
_____ Vivid dreams
_____ Dreams or hallucinations while awake
_____ Paralysis or inability to move upon awakening
_____ Sudden feeling of weakness in legs
_____ Excessive movement during sleep
_____ Legs jerk during sleep
_____ Jaws ache in morning
_____ Grind teeth in sleep
_____ High blood pressure
_____ Gained 10 pounds within past year
_____ Trouble falling asleep
_____ Problems sleeping on back
_____ Caffeine consumption
*If yes, amount consumed per day/week: _____
_____ Alcohol consumption prior to bed time
*If yes, amount consumed per day/week: _____

Current medical treatment:
List all conditions for which you are currently being treated or have received treatment in the last two years:_____
_____
_____

List all surgeries & approximate dates: _____
_____
_____

Have you had a sleep study in the past? _____ If so, list outcome, including use of CPAP:
_____
_____