REM DIAGNOSTICS

Specialists in Sleep Diagnostics

SLEEP HISTORY QUESTIONNAIRE

Name: _____________________________ Age: ______ Ht: ______ Wt: _____

Usual sleep habits:

Bed time: __________ Wake time: _________

Number of times awake to urinate, etc: ___________

Check all that apply:

_____ Excessive daytime sleepiness as evidenced by:

_____ Inappropriate napping

_____ Sleepiness that interferes with activities

_____ Choking sensation associated with awakening

_____ Loud snoring

_____ Non-rested upon awakening

_____ Restless sleep

_____ Trouble with concentration

_____ Witnessed apnea (stop breathing) during sleep

_____ Awaken with headaches

_____ Vivid dreams

_____ Dreams or hallucinations while awake

_____ Paralysis or inability to move upon awakening

_____ Sudden feeling of weakness in legs

_____ Excessive movement during sleep

_____ Leg jerks during sleep

_____ Jaws ache in the morning

_____ Teeth grinding

_____ "Creepy crawly" sensation in legs

Y **N** Caffeine consumption. Amount consumed per day: _____

Y **N** Alcohol consumption. Amount consumed per day / week: __________

Current Medical History:

_____ High blood pressure

_____ Coronary artery disease

_____ Stroke

_____ Diabetes

_____ Mood disorder

_____ Gained 10 pounds with past year

Current Medical Treatment:

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

____

____

____

Previous sleep study? **Y** **N** Currently use CPAP? **Y** **N**