UNM Sandoval Regional Medical Center, Inc.

Adult Sleep History

3001 Broadmoor Blvd. NE – Sleep Disorders Center 3rd Floor – Rio Rancho, NM 87144 (505) 994-7397

Please answer these questions to help us understand your sleep problems. If possible, get help from someone who has seen you sleep (spouse, bed partner, friend, family) to answer these questions:

Patient Name: _____ ***Date of appointment:*** _____
Address: _____
Phone numbers: ***Home (____)*** _____ ***Cell (____)*** _____ ***Work (____)*** _____ ***Other (____)*** _____
Form completed by: _____ ***Date completed:*** _____

Referring Doctor Name and Address _____
_____
Primary Care Doctor Name and Address _____
_____

What is the REASON FOR YOUR VISIT to the Sleep Disorders Center? _____

On typical WEEKDAYS or WORK DAYS:
My bed time is _____ □ *pm* □ *am*
It takes me _____ □ *min* □ *hours* to fall asleep.
My FINAL wake up time is _____ □ *pm* □ *am*
Do you wake up feeling rested? □ YES □ NO

On typical WEEKENDS or DAYS OFF:
My bed time is _____ □ *pm* □ *am*
It takes me _____ □ *min* □ *hours* to fall asleep
My FINAL wake up time is _____ □ *pm* □ *am*
Do you wake up feeling rested? □ YES □ NO

PLEASE CHECK 'YES' OR 'NO' AND FILL IN THE BLANKS:

□ YES □ NO **My bedtimes vary.** If YES, please explain: _____
□ YES □ NO **My morning wake times vary.** If YES, please explain: _____
□ YES □ NO ***Do you take naps during the day?***
If YES: How many naps do you USUALLY take per day? _____
How long is your USUAL nap? _____ □ *min* □ *hours*
Do you wake up feeling rested? □ YES □ NO
□ YES □ NO ***Do you wake up during the night?***
If YES: How many times do you USUALLY wake up? _____
How long do you USUALLY stay awake? _____ □ *min* □ *hours*
What wakes you up? _____
□ YES □ NO ***Do you work shifts?*** If YES: Please describe your work schedule_____
_____

MARK THE BOXES NEXT TO THE STATEMENTS THAT APPLY TO YOU

□ My bedroom is quiet when I sleep.
□ My bedroom is dark when I sleep.
□ My bedroom is a comfortable temperature.
□ My mattress is comfortable.
□ I feel secure in my bedroom.
□ My pet usually sleeps on my bed.
□ I usually read in bed.
□ I usually listen to music or radio in bed.
□ I usually watch television (TV) in bed

□ YES □ NO ***Do you share your bed with anyone?*** If YES: with whom? _____

□ YES □ NO ***Does your bed partner snore or have a sleep disorder?*** IF YES: please explain _____

_____

□ YES □ NO ***Do you take any medicines or herbs (prescribed or over-the-counter) to HELP YOU SLEEP?*** If YES: Please list the name, dose, and frequency _____

_____

□ YES □ NO ***Do you take any medicines or herbs (prescribed or over-the-counter) to HELP YOU STAY AWAKE?*** If YES: Please list the name, dose, and frequency _____

_____

□ YES □ NO ***Do you drink any beverages containing CAFFEINE?***

If YES: Please give more details about HOW MUCH and HOW OFTEN.

Coffee: _____

Hot Tea: _____

Iced Tea: _____

Caffeinated soda (including Mountain Dew, Dr. Pepper, Coke, Pepsi, diet soda, and energy drinks): ___

_____

□ YES □ NO ***Do you drink any beverages containing ALCOHOL?***

If YES: Please give more details about HOW MUCH and HOW OFTEN

Beer _____

Wine _____

Liquor _____

□ YES □ NO ***Have you ever felt you should CUT DOWN on your drinking?***

□ YES □ NO ***Have people ANNOYED you by criticizing your drinking?***

□ YES □ NO ***Have you ever FELT BAD or FELT GUILTY about your drinking?***

□ YES □ NO ***Have you ever had an EYE OPENER (a drink first thing in the morning) to steady your nerves or get rid of a hangover?***

□ YES □ NO ***Do you currently use products containing TOBACCO?***

If YES: Please give us more details about HOW MUCH and HOW OFTEN

Cigarettes _____

Cigar _____

Pipe _____

Chewing tobacco _____

□ YES □ NO ***If you used tobacco in the past, HOW MUCH and for HOW LONG?***

_____

When did you quit? _____

□ YES □ NO ***Have you ever regularly used "recreational" or illegal drugs?***

If YES: Please give us more details about how much and when

Drug _____ How much _____ How often _____

Drug _____ How much _____ How often _____

Drug _____ How much _____ How often _____

□ YES □ NO ***Are you still using any of the above?***

Do you use any of the following within FOUR HOURS of BEDTIME?

□ CAFFEINE □ TOBACCO □ ALCOHOL □ RECREATIONAL DRUGS

How well do you sleep outside of your bedroom in your home (such as on a couch or recliner)?

□ WORSE □ SAME □ BETTER

How well do you sleep outside of your home?

□ WORSE □ SAME □ BETTER

□ YES □ NO ***Do you frequently check the time when you are having trouble falling asleep?***

If YES: How does it make you feel to see the time when you are not sleeping? _____

_____

□ YES □ NO ***Are you anxious or afraid when you get into bed to sleep?***

If YES: Please explain why you feel anxious or afraid. _____

_____

□ YES □ NO ***Do you have uncomfortable (not painful) feelings in your legs?***

If YES: Please describe the feelings in your legs _____

_____

Is it worse at night? _____

What makes it better? _____

_____

How do these feelings in your legs affect your sleep?_____

_____

Do you HAVE or USE at night:

□ Oxygen

□ CPAP or BPAP (bilevel)

□ Bite guard

RATE HOW SLEEPY YOU FEEL DURING THE DAY

How likely are you to DOZE OFF (not just feeling tired or fatigued) in the following situations?
This refers to how sleepy you feel RECENTLY (such as in the last TWO WEEKS).
If you have not these things recently, try to IMAGINE how sleepy you would feel in these situations.

Use the following scale to choose (CIRCLE) the most appropriate number in each situation:

0 = I would NEVER doze off

1 = I would have a SLIGHT CHANCE of dozing off (about 10% of the time)

2 = I would have a MODERATE CHANCE of dozing off (about 50% of the time)

3 = I would have a HIGH CHANCE of dozing off (nearly 100% of the time)

Chance of Dozing

0	1	2	3	Sitting and reading
0	1	2	3	Watching TV
0	1	2	3	Sitting, inactive in a public place (such as in a theater, meeting, classroom, or church)
0	1	2	3	As a passenger in a car for an hour without a break
0	1	2	3	Lying down for a rest in the afternoon when circumstances permit
0	1	2	3	Sitting and talking to someone
0	1	2	3	Sitting quietly after a lunch without alcohol
0	1	2	3	In a car, while stopped for a few minutes in traffic (while at the wheel)

What do you do for exercise? _____

_____

What was your approximate weight 1 year ago: _____ pounds

5 years ago: _____ pounds

Do you have any of the following symptoms? If YES, please check the box:

□ Snoring
□ Wake up gasping for breath or choking
□ Stop breathing during sleep

□ Restless sleep
□ Sweat excessively while asleep
□ Ever wet the bed while asleep

□ Cannot sleep on your back
□ Become short of breath lying down
□ Wake up with heartburn or a sour, stomach-acid taste (acid reflux or indigestion)

□ Wake up with a sore throat
□ Wake up with my heart beating fast or missing beats
□ Wake up confused and disoriented

□ Often have a headache when you wake up
□ Often wake up with nausea or wanting to vomit
□ Often have a dry mouth when you wake up

□ Often have difficulty falling asleep due to shortness of breath or coughing
□ Often have difficulty falling asleep due to sadness or depression
□ Often have difficulty falling asleep due to being anxious or afraid

□ Often have difficulty falling asleep due to racing thoughts
□ Often have difficulty falling asleep due to pain
□ Grind your teeth while asleep

□ Feel paralyzed when going into sleep or when waking up
□ Dream-like visions (hallucinations) even though you know you are awake
□ "Act out" your dreams

□ Frequent nightmares
□ Frequently sleepwalk or talk in your sleep
□ Frequently talk in your sleep

□ Cannot keep your legs still prior to falling asleep
□ Irresistible need to move your legs when lying down or sitting
□ Difficulty driving short distances because of sleepiness

□ Difficulty driving long distances because of sleepiness
□ Problems with relationships or social interactions because of sleepiness
□ Problems with work or education because of sleepiness

□ Problems with concentration and memory because of sleepiness
□ Problems with falling down because of sleepiness
□ Feel depressed

□ Feel anxious or nervous
□ History of physical or emotional trauma
□ Claustrophobia

□ Erectile dysfunction
□ Often have sudden weakness (not dizziness) in the knees, neck, or arms when you are startled, laughing, angry, or emotional

□ Difficulty controlling your blood pressure
□ Difficulty controlling your diabetes / blood sugar
□ Swelling in your feet or ankles

Please list any MEDICATIONS that you CANNOT TAKE because of allergy or side effects:

_____

_____

Please list any other SENSITIVITIES you have (such as seafood, tape, latex):

_____

_____

Please list ALL the medications (including over-the-counter and nutritional supplements) that you are CURRENTLY taking:

Name	Dose	Frequency	Name	Dose	Frequency

Do you HAVE NOW, or have you EVER HAD (check all that apply):

□ Acid reflux (GERD)	□ Chronic pain	□ Heart failure	□ Obesity
□ Alcoholism	□ Coronary artery disease	□ Heart murmur	□ Parkinson's Disease
□ Allergies	□ Dentures	□ Heart surgery	□ Pneumonia
□ Alzheimer's Disease	□ Depression	□ Hepatitis	□ Schizophrenia
□ Anemia	□ Diabetes	□ High blood pressure	□ Seizures / Epilepsy
□ Angina	□ Drug abuse	□ High cholesterol	□ Sinus problems
□ Anxiety	□ Emphysema / COPD	□ HIV	□ Stroke
□ Arthritis	□ Erectile dysfunction	□ Injury to nose	□ Thyroid disease
□ Asthma	□ Fibromyalgia	□ Kidney disease	□ Tonsillectomy
□ Brain injury	□ Head injury	□ Lung surgery	□ Tonsillitis
□ Cancer	□ Heart attack	□ Mental illness	□ Tuberculosis

Please list ANY OTHER MEDICAL PROBLEMS not mentioned above:

_____

_____

_____

Please list any OPERATIONS you have had:

Approximate Date	Type of surgery

Do you have any BLOOD RELATIVES who have or had (check all that apply):

Sleep Related:

□ Anemia
□ Excessive sleepiness
□ Insomnia
□ Loud snoring
□ Narcolepsy
□ Restless Legs Syndrome
□ Sleep apnea
□ Sleepwalking

Other Hx:

□ Alcoholism
□ Alzheimer's Disease
□ Allergies
□ Anxiety
□ Asthma
□ Cancer
□ Coronary artery disease
□ Depression
□ Diabetes
□ Drug abuse
□ Emphysema / COPD
□ Epilepsy / Seizures
□ Heart disease
□ High blood pressure
□ High cholesterol
□ Kidney disease
□ Mental illness
□ Obesity
□ Parkinson's Disease
□ Schizophrenia
□ SIDS or Crib Death
□ Stroke
□ Thyroid disease
□ Tuberculosis

Please list any other significant MEDICAL CONDITIONS that RUN IN THE FAMILY:

_____

I am: □ single □ married □ committed relationship □ widowed

I live: □ alone □ with (describe relationship) _____

_____

I am: □ working □ on disability □ retired □ other: _____

My occupation is / was: _____

The highest level of education I have completed is: _____

□ high school □ college □ post-graduate □ other: _____

My race and/or ethnicity is:

□ Hispanic
□ White / Caucasian
□ Black / African American
□ Native American
□ Asian
□ Other: _____

Please check any symptoms that have bothered you in the LAST TWO WEEKS.

In the LAST TWO WEEKS I have had:

Constitutional

□ Sweating during sleep
□ Fever
□ Chills

Neurologic

□ Headaches
□ Dizziness
□ Fainting

Eyes

□ Double vision
□ Blurred vision
□ Eye irritation or discomfort

ENT

□ Ear pain
□ Nosebleeds
□ Stuffy or congested nose
□ Difficulty swallowing
□ Sore throat

Neck

□ Neck stiffness or pain

Pulmonary

□ Wheezing
□ Shortness of breath at rest
□ Shortness of breath with activity
□ Coughing up blood
□ Nighttime cough

Cardiovascular

□ Chest pain
□ Tightness / pressure in chest
□ Skipped heart beats
□ Palpitations
□ Discomfort in jaw or neck
□ Discomfort in left arm

Gastrointestinal

□ Acid reflux / heartburn
□ Nausea
□ Vomiting
□ Change in bowel habits
□ Blood in stool or black stool

Musculoskeletal

□ Back pain
□ Joint pain
□ Loss of coordination

Genitourinary

□ Frequent nighttime urination
□ Incontinence

Hematologic/Immunologic

□ Abnormal bleeding
□ Easy bruising
□ Infections

Integument

□ Rash
□ Skin sores or lesions
□ Swelling of the feet

Psychologic

□ Anxiety
□ Panic attacks
□ Sad or blue mood
□ Physical or emotional abuse

Functional Outcomes of Sleep Questionnaire

Please circle your answer for each of the following questions. Note that in this questionnaire, when the words "sleepy" or "tired" are used, it describes the feeling that you can't keep your eyes open, your head is droopy, that you want to nod off or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

0 = I don't do this activity for other reasons
1 = Yes, extreme
2 = Yes, moderate
3 = Yes, a little
4 = No

0	1	2	3	4	Do you generally have difficulty concentrating on the things you do because you are sleepy or tired?
0	1	2	3	4	Do you generally have difficulty remembering things because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty finishing a meal because you become sleepy or tired?
0	1	2	3	4	Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?
0	1	2	3	4	Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?
0	1	2	3	4	Do you have difficulty taking care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty performing employed or volunteer work because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?
0	1	2	3	4	Do you have difficulty visiting with your family or friends in your home because you become sleepy or tired?
0	1	2	3	4	Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?
0	1	2	3	4	Do you have difficulty doing things for your family or friends because you are too sleepy or tired?
0	1	2	3	4	Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired?
0	1	2	3	4	Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?

Functional Outcomes of Sleep Questionnaire (continued)

0 = I don't do this activity for other reasons
1 = Yes, extreme
2 = Yes, moderate
3 = Yes, a little
4 = No

0 1 2 3 4	Do you have difficulty watching a movie or videotape because you become sleepy or tired?
0 1 2 3 4	Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?
0 1 2 3 4	Do you have difficulty enjoying a concert because you become sleepy or tired?
0 1 2 3 4	Do you have difficulty watching television because you are sleepy or tired?
0 1 2 3 4	Do you have difficulty participating in religious services, meetings or a group or club because you are sleepy or tired?
0 1 2 3 4	Do you have difficulty being as active as you want to be in the <u>evening</u> because you are sleepy or tired?
0 1 2 3 4	Do you have difficulty being as active as you want to be in the <u>morning</u> because you are sleepy or tired?
0 1 2 3 4	Do you have difficulty being as active as you want to be in the <u>afternoon</u> because you are sleepy or tired?
0 1 2 3 4	Do you have difficulty keeping pace with others your own age because you are sleepy or tired?
0 1 2 3 4	Has your intimate or sexual relationship been affected because you are sleepy or tired?
0 1 2 3 4	Has your desire for intimacy or sex been affected because you are sleepy or tired?
0 1 2 3 4	Has your ability to become sexually aroused been affected because you are sleepy or tired?
0 1 2 3 4	Has your ability to have an orgasm been affected because you are sleepy or tired?
	How would you rate the general level of your activity? Please circle one:

Very low	Low	Medium	High
1	**2**	**3**	**4**

Thank you for completing this questionnaire.

Office use only

*Clinician*_____

*Date*_____ # _____