

SLEEP HISTORY QUESTIONNAIRE
(TO BE COMPLETED BY PATIENT)

Name: _____ Date of birth: _____ Date: _____

ATTENTION PATIENTS:

The physicians of Southeastern Lung Care specialize 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

Greensboro Office (762) 445-1311

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