Premier Health Associates
123 Newton Sparta Road
Newton, NJ 07860

PREMIER
HEALTH ASSOCIATES

Sleep History and Physical Questionnaire

Name _____ DOB: _____ Date _____

Street Address _____

City_____ State_____ Zip _____

Referring Physician (if any) _____

Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information.

1. **What is your chief complaint:** _____
    a. What are your qualify of symptoms: (ex: Mild, Moderate or Severe)_____
    b. Frequency of symptoms: _____
    c. Time of onset and duration of symptoms: _____
    _____
    d. Setting in which symptoms occur:_____
    e. Factors that aggravate or relieve symptoms: _____
    f. What else occurs at the time of symptoms are preset: _____
    _____
    g. Current Height: _____ Current Weight:_____ Current Collar Size:_____

2. **Screening questions for Sleep Apnea**
    a. Do you snore? _____
        i. If so, are you heard outside the bedroom?_____
        ii. Is the snoring worse on your back or on your side?_____
        iii. Do others complain about your snoring? _____
        iv. How many nights per week does it occur? _____
    b. Have you been told that you stop breathing during sleep?_____
    c. Is there a silent period when there is no longer snoring, then followed by loud snore or body jerk? _____
        i. If so, how often? _____
    d. Do you awaken from sleeping short of breath or have a feeling of being choked? _____
    e. Do you perspire at night? _____
    f. Do you wake up with a headache? _____
        i. If so, how bad? (ex: Mild Moderate or Severe)_____
        ii. How long does it last?_____
        iii. Where is the pain located? _____

g. Do you wake up frequently during the night? _____
    i. If so, what wakes you? _____
    ii. When? _____
    iii. How many times per night? _____

3. **Daytime Sleepiness**

a. Do you fall asleep before noon if you are not active? _____
b. Do you fall asleep during active tasks before noon? _____
    i. If so, what tasks are you performing? _____
c. Do you experience sleepiness after lunch? _____
d. Do you fall asleep during the afternoon if you are not active? _____
e. Do you fall asleep during active tasks in the afternoon? _____
    i. If so, what tasks are you performing? _____
f. Do you fall asleep while driving? _____
g. Do you have trouble staying awake during school or work? _____
h. Do you take naps upon arrival home from school or work? _____

4. **Measure of Sleepiness**

a. *Epworth Sleepiness Scale*

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate the most appropriate number for each situation:

0=Would never doze
1=Slight chance of dozing
2=Moderate change of dozing
3=High chance of dozing

Situation	**Chances of Dosing**
a. Sitting and Reading	
b. Watching TV	
c. Sitting, inactive in a public place (Theatre or meeting)	
d. As a passenger in a car for an hour without a break	
e. Lying down to rest in the afternoon when circumstances permit	
f. Sitting and talking with someone	
g. Sitting quietly after a lunch without alcohol	
h. In a car, while stopped for a few minutes in traffic	
Total: (Range 0-24)	

Stanford Sleepiness Scale

Circle or select **ONE** number that best describes your level of alertness or sleepiness **RIGHT NOW**.

1. Feeling active, vital, alert, wide awake: head clear.
2. Functioning at high levels but not a peak; able to concentrate
3. Awake but relaxed; responsive but not fully alert
4. Somewhat foggy: let down
5. Foggy, losing interest in remaining awake; slowed down
6. Sleepy, woozy, fighting sleep; prefer to lie down
7. No longer fighting sleep, sleep onset soon; having dream-like thoughts

b. *Visual Analog Scale of Alertness and Well-Being (circle)*

- How alert do you feel? Very Sleepy 1 2 3 4 5 6 7 Very Alert
- How good do you feel? Very Bad 1 2 3 4 5 6 7 Very good

5. **Screening Questions for Narcolepsy**
   a. Do you feel your knees buckle, your arms feel weak, or jaw drop when you are happy or sad? _____
   b. Do you experience vivid dream-like episodes of scenes upon awakening or falling asleep that you can't tell whether they are real or not? _____
   c. Do you feel paralyzed when waking up or falling asleep?_____
   d. Do you have a history of head trauma or loss of consciousness?_____
   e. Do you have automatic behavior? (ex: Repetitive behaviors without awareness) _____

6. **Screening for Periodic Leg Movements of Sleep**
   a. Do you have leg cramps at bedtime?_____
   b. Do you experience crawling and achy feeling in your legs during the day/night which makes you want to move them or walk? _____
   c. Do you notice that these achy feelings in your legs are worse at nighttime?_____
   d. Have you been told that your legs or arms move every 20 seconds or so during the night? _____
   e. Are your bed covers in total disarray in the morning? _____
   f. Have you ever awakened suddenly with a jerk after falling asleep? _____

7. **Screening for Parasomnias**
   a. Do you remember your dreams?_____
   b. Do you have nightmares? _____
   c. Are you told that you act out dreams in nightmares by swinging your arms, legs, or by moving or yelling? _____
      i. If so, do they occur early or late during the sleep period? _____
   d. Have you hurt yourself or anyone else associated with these movements during the night? _____
   e. Have you been told you sleepwalk? _____

f. Do you sleep talk?_____
    i. If so, can you be understood?_____
    ii. Does this occur in the first third of the night or in the latter third of the night?
    _____
g. Have you been told that you arouse from sleep totally confused or inconsolable?_____
h. Have you awakened feeling panicked with your heart beating uncontrollably?_____
i. Do you have a history of seizures? _____
j. Have you experienced uncontrolled urination in your sleep either as a child or as an adult?
    _____

8. **Screening for Insomnia**

a. Are you unable to fall asleep in 15 minutes or less? _____
b. Do you wake up several times during the night and cannot fall back asleep? _____
c. Do you wake up one or two hours early in the morning?_____
d. Do you have thoughts racing through your mind while trying to fall asleep? _____
e. Do you have anxiety which keeps you from sleeping?_____
f. Do you have muscle tension which can disrupt sleep onset?_____
g. Are you bothered by pain during the day or night?_____
h. Do you wake up feeling stiff in the morning or have sore/achy muscles_____

9. **Screening for Bruxism:**

a. Do you have morning jaw pain?_____
b. Do you grind your teeth during sleep? _____

10. **Sleep Hygiene**

a. What time do you go to bed on weeknights?_____
b. What time do you go to bed on weekends? _____
c. What time do you wake up on weekdays?_____
d. What time do you wake up on weekends? _____

11. **Nocturnal Awakenings:**

a. How many times do you wake up during your sleep? _____
    i. If so, what part of the night is it? _____
    ii. What are the usual causes? _____

12. **Work Schedule**

a. Do you work day shift, middle shift or night shift?_____
b. Do you change shifts from one week to the next?_____
c. Do you travel for work? _____
    i. If so, do you experience jet lag?_____

13. **Circadian Rhythm**

    a. Do you have trouble waking up in the morning and would rather stay up later (ex: 2-3am) and sleep in until noon? _____

    b. Do you go to bed at 8pm to find that you wake up at 3am?

    _____

14. **Habits**

    a. Do you take caffeine? _____

        i. If so, how much per day? _____

        ii. What times during the day are they consumed? _____

    b. Do you take alcohol? _____

        i. If so, how much? _____

        ii. How long before bedtime? _____

    c. Do you smoke? _____

        i. If so, how many packs per day? _____

        ii. For how long? _____

15. **Allergies**

    a. Do you have any allergies to foods, medications, other? _____

        i. If so, please list: _____

        _____

16. **Medications**

    a. Have you taken any medication or had any surgery to help correct your sleep problem? asdasdasd

    b. Are you taking any other over the counter medications of herbal remedies? asdasd

List all of your medications including OTC and Herbal Remedies (or make a copy of your UPDATED med list)

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