WATERBURY HOSPITAL REGIONAL SLEEP LAB
PATIENT HISTORY QUESTIONNAIRE

SLEEP STUDY DATE ____________

Name ________________________ Date of Birth ____________ Weight _________ Height _______

Send Report to Dr. ____

Describe Your Problem ____

____

List any Current Medical or Psychological Problems ______________________________________

____

Usual Bed Times   Weekdays _____ AM/PM to _____ AM/PM
                   Weekends _____ AM/PM to _____ AM/PM

List All Your Medications and the Dose of Each

____

____

____

Do You Fall asleep in the Evening before Bedtime?   No.   Occasionally   Frequently

About How Many Hours of Actual Sleep Do You Get: Weeknights: _______ Weekends:

How Many Times Do You Get Up to Go to the Bathroom Most Nights?

Occupation ____________________   No Current Employment   Retired

If Working, Usual Hours Are: AM/PM to _____ AM/PM

Different Shifts?   No ÁÁ Yes   (Describe) ______________________________________

Other Work Hours ____

How Many Days a Week Do You Nap?   At What Time? _______ For How Long? _______

Weight History   Current _______ 1 Year Ago _______ 5 Years Ago _______

Do You Use Oxygen   No.   Yes--> What Setting? _______   Daytime   Nights   24H/Day

List Any Special Needs You May Have ______________________________________

List Any Medications That Have Caused an Allergic Reaction

____

Previous Sleep Study   No.   Yes--> Where____________ Date _______ Result____________

Have you been given any treatment in the past for snoring, sleep apnea, or other sleep-related problem?   No.   Yes--> Describe ______________________________________

If you were given CPAP, do you use it: Always   Usually   Occasionally   Never

Reason for Not Using ____

If This is a Repeat Study, Are There Any Changes Since This Form Was Originally Completed?

No.   Yes ____

How Commonly Do You Experience Any of the Following?

Symptoms	Never	Rarely	Occasionally	Often
Restless Legs Before or at Bed Time				
Difficulty Getting to Sleep				
Difficulty Remaining Asleep				
Waking Up Because of Snoring				
Awakening with a Gasp				
Awakening Short of Breath				
Awakening With Anxiety or Panic				
Breathing Pauses				
Waking ukp with Heartburn or Acid Reflux				
Night Sweats or Hot Flashes				
Dreams of Exertion or Drowning				
Dreams Beginning Before you Are Asleep				
Repeating or Violent Dreams				
Fatigue on Awakening				
Morning Headache				
Morning Dry Mouth				
Have You Been Told By Others That You Do Any of the Following During Sleep?				
Snore Loudly				
Gasp				
Stop Breathing				
Talk, Walk or Eat				
Kick Your Legs				
Do You Experience:				
Sleepiness Through Day				
Fatigue				
Nasal Congestion				
Difficulty With Memory				
Poor Concentration				
Increased Irritability				
Depression				
Reduced Sex Drive or Performance (Men)				
Becoming Drowsy While Driving				
Needing to Pull Over to Nap				
Falling Asleep Driving				
Sudden Weakness Brough on by				
Anger, Laughter, or other Strong Emotion				

Has Sleepiness Caused an Auto Accident Within the Past Two Years? No Yes

If Yes, Describe ____________________

<u>Average Alcohol Consumption</u> None

Bottles of Beer (#)	Daily	Weekly	Monthly	Yearly
Glasses of Wine (#)	Daily	Weekly	Monthly	Yearly
Shots of Spirits (#)	Daily	Weekly	Monthly	Yearly

List Any Recreational Drug Use and Frequency ____________________ None

<u>Tobacco Smoking History</u> Never Former: _____ Pack/Day for _____ Years Quit Date _____

Current: _____ Pack/Day for _____ Years

Do You Drink Caffeinated Beverages? No Yes--> _____ Ounces or _____ Servings/Day

Family History: Severe Snoring _____ Sleep Apnea _____ Restless Legs _____

Insomnia _____ Narcolepsy _____

Have You Ever Had Any of the Following? (If Yes, give approximate dates)

Admission to Hospital in Coma from Head Injury	No.	Yes	_____
Brain Surgery	No.	Yes	_____
Meningitis or Encephalitis	No.	Yes	_____
Stroke	No.	Yes	_____
Hay Fever or Recurrent Sinus Infection	No.	Yes	_____
Nasal Surgery	No.	Yes	_____
Tonsils or Adenoids Removed	No.	Yes	_____
Surgery for Snoring or Sleep Apnea	No.	Yes	_____
Seizures	No.	Yes	_____

Additional Comments or Information You Feel Important for Us to Know

____

Is it Essential For You to Be Awakened at a Specific Time? No Yes: _____

If You Have a Living Will or Other Health Care Directive, Please Bring a Copy With You.

Be Sure to Bring All of Your Regular or Necessary Medications With You.
The Sleep Lab has no medications available.

PLEASE BRING THIS FORM WITH YOU TO YOUR SLEEP APPOINTMENT

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