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. 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 _____

Average Alcohol Consumption 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

Tobacco Smoking History 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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