

**SLEEP HISTORY QUESTIONNAIRE**  
(TO BE COMPLETED BY PATIENT)

Name: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTENTION PATIENTS:**

**The physicians of Southeastern Lung Care specializes 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**  
**Northlake Office (770) 270-5557**

**Rockdale Office (770) 922-2217**  
**Hillandale Office (678) 518-8000**

**Winn Way Office (404) 508-6257**  
**John's Creek Office (678) 474-9277**