



Paul A. Guillory, M.D. | Renick P. Webb, M.D. | Ernesto J. Garcia, M.D.

Ph: 318.443.1684 • Fax: 318.443.9799 • 221 Windermere Blvd. Alexandria, LA

Name: \_\_\_\_\_  
First Last Middle

Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This Sleep History Packet has been given to you in effort to help your physician gain an in-depth understanding of your Sleep/Medical background and the nature of your current sleep problem(s). **Please complete all the questions as thoroughly as you can.** Once you have completed this packet, **please return it to Red River Sleep Center before your sleep study date.** You may return it by mail or bring it to our office. We sincerely appreciate your cooperation and the opportunity to help you get truly restful sleep. Please be assured that all your information is held in strict confidence.

1. Check the appropriate boxes and use the lines below to describe your main sleep problem(s) and/or sleep complaint(s):

- Difficulty staying asleep
- Wake up too early
- Difficulty waking
- Difficulty staying awake
- Difficulty breathing

---



---



---



---



---

(PLEASE CHECK ALL THAT APPLY)

2. How often do these symptoms occur?  every night  two or more times a week  other \_\_\_\_\_

3. How long have you been experiencing these symptoms?  2+ years  1- 2 years  several months  last few weeks

4. On a scale of 1 to 10, please indicate the severity of your symptoms. (1=mildly upsetting, 10=incapacitating): 1 2 3 4 5 6 7 8 9 10

5. How would you describe your current state of health?  Excellent  Good  Fair  Poor  Very Poor

6. Are you currently on CPAP, Bilevel therapy, other PAP therapy, and/or Oxygen therapy?  Yes |  No

7. Do you have difficulty with?  Thinking  Remembering  Reasoning  Other \_\_\_\_\_

8. Do you have family with sleep disorders? explain: \_\_\_\_\_

---

9. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

- General Practitioner
- Chiropractor
- Osteopath
- Nutritionist
- Counselor
- Obstetrics/Gynecology
- Cardiologist
- Other Internists
- Social Worker
- Clergyman
- Other Physician
- Psychiatrist
- Clinical Psychologist
- Nurse
- Other

N: Never

R: Rarely

O: Occasionally

F: Frequently

C: Constantly

14. **Please rate how often you:**

Snore	N	R	O	F	C
Snore in all positions	N	R	O	F	C
Snore loudly enough that others complain	N	R	O	F	C
Stop breathing during sleep (observed by self or others)	N	R	O	F	C
Suddenly wake up gasping for breath during the night	N	R	O	F	C
Awaken from sleep short of breath	N	R	O	F	C
Awaken at night with heartburn, belching or cough	N	R	O	F	C
Have morning headaches	N	R	O	F	C
Sweat excessively at night	N	R	O	F	C
Notice your heart pounding or beating irregularly during the night	N	R	O	F	C
Fall asleep during the day, even after a full night's sleep	N	R	O	F	C
Fall asleep involuntarily	N	R	O	F	C
Fall asleep while driving	N	R	O	F	C
Fall asleep during physical effort	N	R	O	F	C
Fall asleep when laughing or crying	N	R	O	F	C
Experience loss of muscle tone when extremely emotional	N	R	O	F	C
Have trouble at school or work because of sleep	N	R	O	F	C
Feel unable to move (paralyzed) when waking or falling asleep	N	R	O	F	C
Experience vivid dreamlike scenes upon awakening or falling asleep	N	R	O	F	C
Feel afraid of going to sleep	N	R	O	F	C
Have frequent nightmares	N	R	O	F	C
Remember your dreams	N	R	O	F	C
Feel sad or depressed	N	R	O	F	C
Have anxiety (worry about things)	N	R	O	F	C
Notice parts of your body jerk	N	R	O	F	C
Kick during the night	N	R	O	F	C
Experience crawling and aching feelings in your legs	N	R	O	F	C
Experience any type of leg pain during the night	N	R	O	F	C
Have morning jaw pain	N	R	O	F	C
Grind teeth during sleep	N	R	O	F	C

**N:** Never

**R:** Rarely

**O:** Occasionally

**F:** Frequently

**C:** Constantly

Are bothered by pain during the day	N	R	O	F	C
Are awakened by pain during the night	N	R	O	F	C
Wake up feeling stiff in the morning	N	R	O	F	C
Wake up with sore or achy muscles	N	R	O	F	C
Have muscular tension	N	R	O	F	C
Wake up with pain in neck, spine or joints	N	R	O	F	C

15. Is your present work situation satisfactory?  Yes |  No

16. **UNDERLINE** any of the following that apply to you:

feel panicky	panicky	restless	evil	horrible thoughts
suicidal ideas	repulsive	agitated	ugly	memory problems
full of regrets	feel tense	confused	naïve	financial problems
take sedatives	worthless	attractive	bored	can't make friends
"life is empty"	worthwhile	confident	guilty	can't make decisions
fainting spells	inadequate	cowardly	stupid	home conditions bad
misunderstood	nightmares	take drugs	hostile	"can't do anything right"
morally wrong	unassertive	depressed	lonely	concentration difficulties
over ambitious	unattractive	intelligent	useless	unable to have a good time
unable to relax	considerate	alcoholism	anxious	full of hate inferiority feelings
can't keep a job	incompetent	aggressive	unloved	don't like weekends and vacations
shy with people	unconfident	a "nobody"	deformed	take antacids regularly (Tums, Tagamet, etc)
sexual problems	sympathetic	no appetite	in conflict	other: _____

18. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? Please explain? \_\_\_\_\_  
 \_\_\_\_\_

19. How many hours of sleep do you usually get per night? \_\_\_\_\_

20. What time do you usually go to bed on WEEKDAYS? \_\_\_\_\_ WEEKENDS? \_\_\_\_\_

21. How long does it take for you to fall asleep? \_\_\_\_\_

22. How many times do you typically wake up at night? \_\_\_\_\_

23. If you wake up, on the average, how long do you stay awake? \_\_\_\_\_

24. After falling asleep, what part of the night do you wake up most often?  soon after falling asleep |  middle of the night |  early morning

25. What do you usually do when you awaken during the night? \_\_\_\_\_

26. What time do you usually get out of bed WEEKDAYS \_\_\_\_\_ WEEKENDS? \_\_\_\_\_

27. Are your sleep habits on weekends different from the rest of the week?  
 No |  Yes, please describe \_\_\_\_\_

28. Do you usually: (Check all that apply to you)
- sleep with someone else in your bed |  sleep with someone else in your room |  Provide assistance to someone during the night (child, invalid, bed partner, animal)
29. With whom are you now living? (wife, husband, children, parents, etc., please list ages) \_\_\_\_\_  
\_\_\_\_\_
30. Do you work split shifts or rotating (variable) shifts?..... Yes |  No
31. Have you changed your diet recently?  Yes |  No, please explain: \_\_\_\_\_
32. Do you exercise regularly?  Yes |  No || Do you exercise close to bedtime?  Yes |  No
33. Do you:  Read before falling asleep  Watch TV  Other:\_\_\_\_\_
34. Do you take naps during the afternoon or evening?..... Yes |  No
35. Do you feel refreshed after a short (10-15 minute) nap?..... Yes |  No
36. How do you feel after an average night of sleep?
- Drowsy and/or tired.....For how long:  1 hour |  2 hours |  3 hours or longer
- Rested and/or refreshed.....For how long:  1 hour |  2 hours |  3 hours or longer
37. When do you feel at your best?  Morning |  Afternoon |  Evening
38. Have ever had a head injury?  Yes |  No, explain: \_\_\_\_\_
39. Are you handicapped?  Yes |  No, IF YES - Do you require an help getting up and down or help going to the restroom?  Yes |  No
40. Do you require any special assistance?  Yes |  No, IF YES - please describe? \_\_\_\_\_  
\_\_\_\_\_
41. Do you have trouble with incontinence?  Yes |  No
42. In response to intense emotion (laughter, anger, surprise) have you felt sudden muscle weakness in your legs, neck, arms, etc?  Yes |  No  
If yes, please describe emotions involved and what muscles were weakened or went limp.  
\_\_\_\_\_
43. Before you are fully asleep do you have very vivid, sometimes frightening, hallucination like dreams?  Yes |  No
44. Have you ever awakened and felt like your body was "paralyzed", or couldn't move at all, even though you could breathe and see?  Yes |  No
45. Do you have difficulty falling asleep because your legs are restless or have crawling sensation?  Yes |  No
46. Please check any of the following sleep behaviors that occurred when you were a child or an adolescent:
- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> sleep walking  | <input type="checkbox"/> inability to sleep until late | <input type="checkbox"/> twitching or jerking | <input type="checkbox"/> head banging                       |
| <input type="checkbox"/> snoring/asthma | <input type="checkbox"/> grinding teeth excessive      | <input type="checkbox"/> sleepiness in school | <input type="checkbox"/> seizures in sleep                  |
| <input type="checkbox"/> sleep talking  | <input type="checkbox"/> insomnia                      | <input type="checkbox"/> bed wetting          | <input type="checkbox"/> night terrors/screaming & shouting |

**WEIGHT:** Within last year - GAINED \_\_\_\_\_ LOST \_\_\_\_\_ | within last 5 years - GAINED \_\_\_\_\_ LOST \_\_\_\_\_

**TOBACCO:**

Do you smoke?.....  Yes |  No

Did you previously smoke?.....  Yes |  No

How many years of smoking? \_\_\_\_\_

How much per day? \_\_\_\_\_

Do you use other tobacco products?...  Yes |  No

How much per day? \_\_\_\_\_

How close to bedtime do you use any tobacco products?  
\_\_\_\_\_

**ALCOHOL:**

Do you drink alcohol?.....  Yes |  No

How much? \_\_\_\_\_ drinks per (day / week / month) {please circle}

**CAFFEINE/STIMULANT:**

List your consumption of the following per day:

coffee, tea, colas, chocolate, other caffeinated products/stimulants: \_\_\_\_\_

\_\_\_\_\_

How close to bedtime do you consume any caffeinated products? \_\_\_\_\_

**NONPRESCRIPTION, OVER THE COUNTER, & OTHER DRUGS: (PLEASE LIST BELOW)**

\_\_\_\_\_  
\_\_\_\_\_

**SLEEP ENVIRONMENT: (PLEASE CHECK ALL THAT APPLY)**

Is your mattress?  soft |  hard |  just right

Is your bedroom?  loud |  quiet &  light |  dark

Do you fall asleep with the television on?  Yes |  No ... With radio on?  Yes |  No

Is your sleep disturbed by?  heat |  light |  bed partner |  different bed |  cold |  noise |  other \_\_\_\_\_

**ALLERGIES:** Are you allergic to Latex, tape or adhesive?  Yes |  No ~ Do you have any other allergies, drug or otherwise? (Please list all known allergies in the space provided) \_\_\_\_\_  
\_\_\_\_\_

**PAIN ASSESSMENT:** Do you experience pain/discomfort?  Yes |  No

What is the location and how often do you experience this pain/discomfort? \_\_\_\_\_  
\_\_\_\_\_

**FALL ASSESSMENT:**

How many falls have you experienced in the last 10 years? \_\_\_\_\_ Do you require assistance walking or getting around?  Yes |  No

Have you sustained any injuries from falls in the last 10 years?  Yes |  No.....If yes, please list all injuries: \_\_\_\_\_  
\_\_\_\_\_

Have you sustained any injuries, to any degree, in the last year? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_



# Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you haven't done some of these activities recently, please try to estimate how you would typically respond. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze      1 = slight chance of dozing      2 = moderate chance of dozing      3 = high chance of dozing

**Situation** \_\_\_\_\_ **Chance of Dozing**

- \* Watching TV \_\_\_\_\_
- \* Sitting and reading \_\_\_\_\_
- \* Sitting and talking with someone \_\_\_\_\_
- \* Sitting quietly after a lunch without alcohol \_\_\_\_\_
- \* As a passenger in a car for an hour without a break \_\_\_\_\_
- \* In a car, while stopped for a few minutes in the traffic \_\_\_\_\_
- \* Sitting inactive in a public place (ex: a theater or a meeting) \_\_\_\_\_
- \* Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_

Epworth  
Score:

\_\_\_\_\_

## BED PARTNER QUESTIONNAIRE

Name of person completing this form \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

I have observed this person's sleep:     every night     often     sometimes

**Check any of the following behaviors that you have observed this person doing while asleep.**

- light snoring       loud snoring       occasional loud snorts       choking       pauses in breathing
- twitching/kicking legs     grinding teeth       sleep walking       acting out dreams       talking during sleep
- bedwetting       biting tongue       head banging/rocking       crying out       sitting up in bed
- apparently sleeping although he/she behaves otherwise     becoming very rigid and or shaking     snores loudest while sleeping on back
- getting out of bed, but not awake     other \_\_\_\_\_

Please describe the sleep behavior(s) you checked above in further detail. Include: (1) a description of the activity, (2) the time of night it occurs, (3) how often during the night, and (4) whether it occurs every night.

---



---



---



---



---

*Thank you!*