FOR OFFICE USE ONLY

PT MRN:______________
PROVIDER:____________

**Sleep Center**
303.270.2708
303.270.2109 Fax

*Main Campus*
1400 Jackson Street
Denver, CO 80206

*Highlands Ranch Location*
8671 S. Quebec St., Ste 120
Highlands Ranch, CO 80130

# Insomnia Clinic Sleep History Questionnaire – Please print clearly

**PRIOR TO SCHEDULING:**

1. **A referral with a diagnosis of INSOMNIA** from the patient's physician must be sent to National Jewish Health Sleep Center, regardless of insurance.
2. Patient to submit completed questionnaire and attached documents. Fax to 303.270.2109
3. If required by your insurance, an authorization needs to be sent to National Jewish Health Sleep Center. Please have this faxed to 303.270.2109.

## DEMOGRAPHICS

Patient name:______________________________________________

Phone:______________________ Home Mobile Work (circle one)

Street address:______________________ City/State/Zip:______________________

Date of birth:__________ Age:______ Gender: ______M ______F ______Other:__________

Education (years of school):______________________ Occupation:______________________

Marital status:______________ Years:______ Number of children:______________

## SLEEP HISTORY

Please describe your current sleep problem:______________________________________________

______________________________________________

______________________________________________

How long have you had this problem?______________________________________________

What do you feel is the major cause(s) of your sleep problem?______________________________

______________________________________________

Describe any treatments you have had for your sleep problem and how well they have worked: ______________

______________________________________________

______________________________________________

Please describe any childhood sleep problems:______________________________________________

______________________________________________

List any previous sleep studies you have had (date and name of facility). **PLEASE NOTE, WE NEED A COPY OF ANY PRIOR SLEEP STUDY RECORDS.**

______________________________________________

______________________________________________

Patient Name:___________________________

| SLEEP SCHEDULE | ON A GOOD NIGHT | ON A BAD NIGHT |
|---|---|---|
| What time do you get into bed at night? | | |
| What time do you try to fall asleep? | | |
| How long does it take to fall asleep? | | |
| What time do you wake up? | | |
| Average number of hours of sleep per night: | | |
| Number of awakenings per night: | | |

How do you feel upon awakening?_______________________________________________________________

How often do you travel across time zones per month?_________________________________________________

| YES | NO | SLEEP SCHEDULE |
|---|---|---|
| | | Do you do shift work or work at night? |
| | | Do you take naps during the day? If yes, how many times per week?________________________<br>If so, how long do you nap?_________________ What time?______________________________ |

**ACTIVITIES YOU DO IN BED AT NIGHT** – ***PLEASE CHECK THE MOST APPROPRIATE ANSWER***

| ACTIVITY | EVERY NIGHT | 2-3 NIGHTS PER WEEK | 1 NIGHT PER WEEK | 2-3 NIGHTS PER MONTH | LESS THAN MONTHLY | NEVER |
|---|---|---|---|---|---|---|
| Watch TV | | | | | | |
| Read | | | | | | |
| Radio/Audio | | | | | | |
| Eat | | | | | | |
| Phone | | | | | | |
| Work/study | | | | | | |
| Computer | | | | | | |

**On a scale of 1 to 10 (see scale below), please rate how much difficulty you have with:**

no difficulty — some difficulty — great difficulty

1 2 3 4 5 6 7 8 9 10

| | |
|---|---|
| Relaxing your body at bedtime | |
| "Slowing down" or "turning off" your mind while trying to sleep | |

**BED PARTNER**

☐ Sleep alone ☐ With bed partner ☐ With pets ☐ With children (co-sleeping)

Please list anything your bed partner does that interferes with your sleep:________________________________________

**CURRENT SLEEP SYMPTOMS** – ***PLEASE CHECK ALL THAT APPLY***

| | | | |
|---|---|---|---|
| | Excessive daytime sleepiness | | Unpleasant sensations in legs at night or at bedtime |
| | Drowsy driving | | Twitching or jerking of your legs during sleep |
| | Recent accident or near miss due to drowsiness | | Frequent disturbing dreams or nightmares |
| | Insomnia (difficulty falling or staying asleep) | | Unusual movements or behavior during sleep |
| | Frequent snoring | | Sleepwalking |
| | Wake up gasping, choking, or feeling short of breath | | Losing muscle strength if laughing, excited, angry |
| | Witnessed apneas (breath holding during sleep) | | Seeing or hearing things as you fall asleep/wake up |
| | Excessive sweating during sleep | | Feeling unable to move as you fall asleep/wake up |
| | Nighttime heartburn | | Teeth clenching/grinding |
| | Headaches upon awakening | **Other:** | |

Patient Name:_________________________

| REVIEW OF SYSTEMS – *OVER THE PAST 12 MONTHS* | | | | | |
|---|---|---|---|---|---|
| √ | **PROBLEM** | √ | **PROBLEM** | √ | **PROBLEM** |
| | Arthritis | | Asthma | | Chronic pain |
| | Depression | | Diabetes | | Memory/Concentration Problems |
| | Emphysema/COPD | | Epilepsy | | Headaches |
| | Heartburn/Ulcers | | High Blood Pressure | | Hallucinations/Delusions |
| | Kidney Problems | | Hiatal Hernia | | Childhood Hyperactivity |
| | Panic Attacks | | Nose/Throat Problems | | Alcohol/Drug Problems |
| | Sexual Problems | | Anxiety/Nervousness | | Loss of Sex Drive |
| | Stroke | | Suicide Attempts | | Swelling Ankles |
| | Thyroid Problems | | Cold/Heat Intolerance | | Trouble Breathing at Night |
| | Changes in Hair or Skin | **Other:** | | | |

**MEDICATIONS – PRESCRIBED AND OVER THE COUNTER**

**PLEASE LIST MEDICATIONS YOU ARE TAKING OR HAVE RECENTLY STOPPED TAKING (IN THE PAST 12 MONTHS)** (continue on back of page or attach current list if needed)

| MEDICATION | DOSAGE AND FREQUENCY (e.g., daily, as needed, etc.) | REASON | CURRENT? (YES/NO) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**SLEEP AIDS**

Currently, how many times per month do you use medications to help you sleep?_________________________________

Currently, how much alcohol do you use to help you sleep?___________Amount per night_________Times per month

| *Please indicate yes/no and how much per day:* | **YES** | **NO** | **How much per day?** |
|---|---|---|---|
| Caffeinated coffee | | | |
| Caffeinated tea | | | |
| Caffeinated soda | | | |
| Energy drinks | | | |
| Smoking, chewing tobacco, or e-cigarettes | | | |
| Alcohol | | | |
| Recreational drugs including marijuana | | | |
| Exercise | | | |

**ADDITIONAL MENTAL HEALTH HISTORY**

| **Have you ever been treated by the following?** | **Yes/No** | **When and for what** | **Name of facility/provider** |
|---|---|---|---|
| Psychiatrist/psychiatric prescriber | | | |
| Psychologist/counselor | | | |

Patient Name:________________________

## EPWORTH SLEEPINESS SCALE

**How likely are you to doze off or fall asleep in the following situations?**

This refers to your usual way of life in **recent times**. If you have not done some of these things recently, try to estimate how they might have affected you. Use the following scale to rate your chance of dozing in the following situations:

**0 – Never  1 – Slight chance  2 – Moderate chance  3 – High chance**

| SITUATIONS | SCORE |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive, in a public place | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.

## INSOMNIA SEVERITY INDEX

***PLEASE RATE THE CURRENT (LAST 2 WEEKS) SEVERITY OF THE FOLLOWING:***

| PROBLEM | NONE | MILD | MODERATE | SEVERE | VERY |
|---|---|---|---|---|---|
| Difficulty falling asleep | | | | | |
| Difficulty staying asleep | | | | | |
| Waking up too early | | | | | |

| PROBLEM | NOT AT ALL | A LITTLE | SOMEWHAT | MUCH | VERY MUCH |
|---|---|---|---|---|---|
| How satisfied are you with your current sleep pattern? | | | | | |
| How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life? | | | | | |
| How worried are you about your current sleep problem? | | | | | |
| How much does your sleep problem interfere with your daily functioning (daytime fatigue, mood, ability to function at work/chores, concentration, memory, etc)? | | | | | |

Please register for a National Jewish Health patient portal account at **nationaljewish.org**

*This will allow you to request prescription refills, view your schedule, request appointments or cancellations, communicate with your care team, and much more.*

National Jewish Health is a fragrance-free, non-smoking facility. Please do not wear perfumes, colognes, aftershave, scented lotions or scented hairspray as these can irritate and increase respiratory symptoms in our patients and care team.