Weill Cornell Medical College

NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health

SLEEP HISTORY QUESTIONNAIRE

Name: Date:

Date of Birth: Age:

Occupation: Sex: Height:

Current Weight: Weight Last Year:

Pediatrician: Referring Physician:

Describe your sleep problem?

What results do you expect?

A. MEDICATION SURVEY

Please list all prescription and non-prescription medicatiaons you are currently taking.

MEDICATION	REASON TAKEN	DOSE

ALLERGIES:

B. PLEASE LIST ALL PAST OR PRESENT MEDICAL CONDITIONS OR SURGERIES

MEDICAL CONDITIONS	SURGERIES

C. SLEEP PATTERN

Circle the days of the week you work/go to school:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

ON WORKDAYS

A. What time do you go to bed?
B. What time do you get out of bed?

ON WEEKENDS AND HOLIDAYS

A. What time do you go to bed?
B. What time do you get out of bed?

How long does it take for you to fall asleep?

How many times a night do you awaken?

A. How long do the awakenings last?
B. List any symptoms associated with the awakenings:

SLEEP TIME

A. How many hours do you usually sleep? (do not include hours spent in bed awake)
B. How many hours does it take to make you feel rested?
C. How many daytime naps to do you take per week?

SLEEP QUALITY

A. Do you feel unrefreshed and still sleepy upon awakening? ☐ Yes ☐ No
B. How long does it take to fully awaken in the morning?

In the daytime, are you chronically sleepy, fatigued or tired? ☐ Yes ☐ No

Grade your tendency to fall asleep during the following situations:
(0 = would never fall asleep, 1 = slight chance of sleeping, 2 = moderate change of sleeping, 3 = high chance of sleeping)

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g theater or meeting)	☐	☐	☐	☐
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 lunch without alcohol	☐	☐	☐	☐
In a car while stopped for a few minutes	☐	☐	☐	☐

D. SLEEP AND BREATHING

1. Do you snore? ☐ Yes ☐ No
2. Is your snoring broken by hesitations, gasps and snorts? ☐ Yes ☐ No
3. Are the hesitations long enough to frighten your family members or sleep partner? ☐ Yes ☐ No
4. Has you snoring driven your bed partner/family member from the bedroom? ☐ Yes ☐ No
5. Do you awaken with a dry mouth? ☐ Yes ☐ No
6. Do you awaken with headaches? ☐ Yes ☐ No

E. FALLING ASLEEP

1. Do you have trouble falling or staying asleep? ☐ Yes ☐ No
2. Do you worry about being able to fall asleep on time? ☐ Yes ☐ No
3. Do you feel sleepy prior to getting into bed? ☐ Yes ☐ No
4. Does you mind race with thoughts when lying awake? ☐ Yes ☐ No
5. Do daytime worries keep you awake at night? ☐ Yes ☐ No
6. Does pain distrub your sleep? ☐ Yes ☐ No
7. Does heat, cold, hunger or thirst disturb your sleep? ☐ Yes ☐ No
8. Does the problem falling asleep affect your life? ☐ Yes ☐ No

If yes, how and to what degree:

9. Do you rely on a sleeping medicaton? ☐ Yes ☐ No
10. Do you watch TV, read, or work in bed? ☐ Yes ☐ No
11. Do you frequently travel across 2 or more time zones? ☐ Yes ☐ No

F. SLEEP DISTURBANCES

1. Do you experience unpleasant leg sensations at bedtime? ☐ Yes ☐ No
2. Do you kick or jerk your legs and/or arms during sleep? ☐ Yes ☐ No
3. Do you have sweats or awaken from sleep feeling flushed? ☐ Yes ☐ No
4. Do you awaken with a bitter or acid taste? ☐ Yes ☐ No
5. Do you frequently have nightmares or vivid dreams? ☐ Yes ☐ No
6. Do you grind your teeth or have bitten your cheek during sleep? ☐ Yes ☐ No
7. Have you ever walked or talked in your sleep? ☐ Yes ☐ No
8. Have you ever been unable to move for a few moments after awakening? ☐ Yes ☐ No
9. Have you ever seen or felt things from your dreams after awakening? ☐ Yes ☐ No
10. Have you ever experienced weakness when laughing or angry? ☐ Yes ☐ No
11. Have you ever had unusual movements or behaviors during sleep? ☐ Yes ☐ No

If yes, please describe:

G. PERSONAL HABITS

1. Do you smoke now or have you in the past? ☐ Yes ☐ No

If yes, how many per day and for how many years?
If yes, what time of day is your last use?

2. Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks? ☐ per day ☐ per week ☐ per month
If yes, what time of day is your last drink?

3. How many caffeinated beverages do you drink per day?

If yes, what time of day is your last drink?

H. FAMILY HISTORY

	AGE	MEDICAL CONDITIONS
Father		
Mother		
Sibiling 1		
Sibling 2		
Sibling 3		
Uncles/Aunts		
Grandparents		

(Continue below if necessary.)

List any relatives who have sleep problems or snore:

I. PERSONAL HISTORY (Check any and all that apply)

- ☐ Skipped heart beats
- ☐ Heart failure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stroke
- ☐ Epilepsy
- ☐ Headaches
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Nasal congestion
- ☐ Deviated nasal septum
- ☐ Enlarged tonsils
- ☐ Allergies
- ☐ Asthma
- ☐ Glaucoma
- ☐ Depression/Anxiety
- ☐ Bipolar disorder

K. ANY ADDITIONAL INFORMATION:

Patient's/Representative's Name Patient's/Representative's Signature Date

Relationship to Patient:

Physician's Signature Date

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: