



## SLEEP HISTORY – Alliance ENT

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### HEIGHT AND WEIGHT

What is your height? \_\_\_\_\_  
What is your weight? \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_

### MEDICATION

Do you take anything to help you sleep? Y/N What? \_\_\_\_\_ How often? \_\_\_\_\_  
List current medications (and dosages) that might affect your sleep, including both prescriptions and over-the-counter medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PLEASE USE THE SCALE:

0= never 1=rarely 2=occasionally 3=frequently 4=daily

- \_\_\_ Do you have a bedmate?
- \_\_\_ Do you and your bedmate sleep in separate rooms?
- \_\_\_ Does your bedmate or others notice loud snoring?
- \_\_\_ Has someone noticed your breathing during sleep being irregular (pauses, gasps or choking)?
- \_\_\_ Do you feel refreshed when you awaken?
- \_\_\_ Do you have trouble falling to asleep or staying asleep?
- \_\_\_ Do you awaken too early?
- \_\_\_ Do you feel that your legs are restless or that they kick at night?
- \_\_\_ Do you sleep walk?
- \_\_\_ Do you have frequent nighttime urination?
- \_\_\_ Do you have difficulty breathing through your nose at night?
- \_\_\_ Do you have acid reflux?
- \_\_\_ Do you become sleepy during the day? (Check any that apply)  
\_\_\_sitting \_\_\_riding \_\_\_driving \_\_\_standing
- \_\_\_ Do you take naps?
- \_\_\_ Do you exercise?
  
- \_\_\_ Do you have poor concentration, trouble with memory or feel irritable?
- \_\_\_ Do you have high blood pressure?
- \_\_\_ Do you wear partial or complete dentures?
- \_\_\_ Are your sleep patterns affecting your work?