Sleep History Questionnaire
The Proponent Agency is MCXC-MED-PUL

Name: _____ DOB: _____ Age: _____ Gender: ☐ Male ☐ Female

Civilian ☐ Retired ☐ Active Duty ☐ MOS: _____

Can we leave a detailed voice mail? **Yes** ☐ **No** ☐

ADMIN USE ONLY		
ESS:	*ISI:*	*FOSQ:*

Primary Phone #: _____ Secondary #: _____ Work#: _____

Can we email you? **Yes** ☐ **No** ☐ **Email**: _____ Undergoing MEB? **Yes** ☐ **No** ☐

Possible Deployment in future? **Yes** ☐ **No** ☐ If yes, When? (Mo/Yr): _____

Planned ETS? **Yes** ☐ **No** ☐ If yes, When? (Mo/Yr): _____

Previous Sleep Study? **Yes** ☐ **No** ☐ If yes, When? (Mo/Yr): _____

If yes, where was the study performed and what were the results? _____

Have you previously been diagnosed with a sleep disorder? **Yes** ☐ **No** ☐ Describe the problem and previous treatments:

What problems are you having with your sleep? _____

SLEEP QUALITY

Some people have difficulty performing everyday activities when they feel tired or sleepy.
In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap.
These words do not refer to the tired or fatigued feeling you may have after you have exercised.

(0) = Do not do activity	**(1) = Extreme Difficulty**	**(2)= Moderate Difficulty**	**(3) = A Little Difficulty**	**(4) = No Difficulty**

1)	Do you have difficulty concentrating on the things you do because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	Average (1,2) = ___
2)	Do you generally have difficulty remembering things because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	
3)	Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	Average (3,4,5) = ___
4)	Do you have difficulty operating a motor vehicle for long distances (more than 100 miles) because you become sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	
5)	Do you have difficulty watching a movie or video because you become sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	
6)	Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	Average (6,7,8) = ___
7)	Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	
8)	Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	
9)	Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	(9)= ___
10)	Do you have decreased desire for physical intimacy because you are sleepy or tired?	**0 4 3 2 1** ☐ ☐ ☐ ☐ ☐	(10)= ___

FOSQ-10 Total: ___/20

How often do you:	Never	Sometimes	Routinely
Snore?	☐	☐	☐
Stop breathing while you sleep?	☐	☐	☐
Awake gasping, choking, coughing or snoring?	☐	☐	☐
Have morning headaches?	☐	☐	☐
Wake with a dry mouth and/ or a sore throat?	☐	☐	☐

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INSOMNIA

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None(0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Difficulty falling asleep	☐	☐	☐	☐	☐
Difficulty staying asleep	☐	☐	☐	☐	☐
Waking up too early	☐	☐	☐	☐	☐

How SATISFIED/ DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied ☐ ***(0)*** | ***Satisfied*** ☐ ***(1)*** | ***Neutral*** ☐ ***(2)*** | ***Dissatisfied*** ☐ ***(3)*** | ***Very Dissatisfied*** ☐ ***(4)***

How NOTICEABLE to *others,* do you think your sleep problem is in terms of impairing the quality of your life?

Not Noticeable ☐ ***(0)*** | ***A Little*** ☐ ***(1)*** | ***Some*** ☐ ***(2)*** | ***Much*** ☐ ***(3)*** | ***Very Noticeable*** ☐ ***(4)***

How WORRIED/ DISTRESSED are you about your current sleep problem?

Not Worried ☐ ***(0)*** | ***A Little*** ☐ ***(1)*** | ***Some*** ☐ ***(2)*** | ***Much*** ☐ ***(3)*** | ***Very Worried*** ☐ ***(4)***

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, etc.) CURRENTLY?

Not Interfering ☐ ***(0)*** | ***A Little*** ☐ ***(1)*** | ***Some*** ☐ ***(2)*** | ***Much*** ☐ ***(3)*** | ***Very Interfering*** ☐ ***(4)***

ISI TOTAL: ___/28

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. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = never go to sleep; 1 = slight chance of going to sleep; 2 = moderate chance of going to sleep; 3 = high chance of going to sleep

SITUATION	CHANCE OF GOING TO SLEEP 0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (meeting, theater)	☐	☐	☐	☐
As a passenger in a car riding for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon (if time permits)	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car stopped in traffic for a few minutes	☐	☐	☐	☐

ESS TOTAL: ___/24

Note: For the purposes of this questionnaire, the term "**night**" refers to your major sleep period. The term "sleepy" refers to feeling like you need to sleep as opposed to just feeling tired.

Sleep Schedule & Sleep Hygiene	Work Days	Non-Work Days
What time do you typically get into bed?		
What time do you typically attempt to fall asleep?		
How long does it usually take you to fall asleep?		
On average, how *many* times do you wake up at night?		
What time do you physically get out of bed in the morning?		

If you take naps (including dozing off for a few minutes), how many, what time of day, and for how long?	# of Naps	Time of day	Minutes	# of Naps	Time of day	Minutes

Do you feel well rested upon awakening? Yes ☐ No ☐

Do you look at the clock frequently at night? Yes ☐ No ☐

Do you currently do shift work? Yes ☐ No ☐

Do you use electronics in bed? (TV, phone, etc) Yes ☐ No ☐

Do you have a bed partner? Yes ☐ No ☐

Have you done shift work in the past? Yes ☐ No ☐

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Name:

PARASOMNIA/OTHER	Unknown	Yes	No
Do you grind your teeth when you sleep?	☐	☐	☐
Do you sleep walk?	☐	☐	☐
Do you experience frequent nightmares?	☐	☐	☐
If yes, are the nightmares combat or trauma related?	☐	☐	☐
If you have nightmares, are they recurrent?	☐	☐	☐
Do you act out your dreams?	☐	☐	☐
Do you ever hallucinate when falling asleep or waking up?	☐	☐	☐
Are you ever unable to move while going to sleep or waking up?	☐	☐	☐
During intense emotions (i.e. laughing, anger, startled, etc.) have you ever had the sudden onset of muscle weakness?	☐	☐	☐
Do you experience sudden and/or uncontrolled sleep attacks?	☐	☐	☐
Have you had a driving accident or near miss accident because you were sleepy?	☐	☐	☐
Does Pain affect your sleep?	☐	☐	☐

If yes, please rate your average pain level during sleep from 1 – 10 with one being no pain and 10 the most pain. ___ / 10

RESTLESS LEGS	Yes	No
Do you experience uncomfortable sensations in your legs and feel like you have to move them?	☐	☐
Do these uncomfortable sensations occur with rest and relaxation?	☐	☐
Does moving your legs improve or relieve the uncomfortable sensations?	☐	☐
Are the uncomfortable sensations in your legs worse in the evening?	☐	☐

SOCIAL HISTORY

	Yes	No	How Much
Do you drink alcoholic beverages?	☐	☐	_____ /Per Week
Do you drink caffeinated beverages?	☐	☐	_____ /Per Day
Do you use workout supplements or other stimulants?	☐	☐	_____ /Per Week
Do you use tobacco products or electronic cigarettes?	☐	☐	_____ /Per Week

Check all that apply: ☐ Smokeless Tobacco ☐ Cigars ☐ Cigarettes ☐ E-Cigarettes

REVIEW OF SYSTEMS (check all that apply)

☐ Fatigue	☐ Fever/chills	☐ Night sweats
☐ Unintentional weight loss	☐ Weight gain	☐ Jaw or TMJ pain
☐ Visual changes	☐ Double vision	☐ Eye Pain
☐ Chest pain	☐ Palpitations	☐ Leg swelling
☐ Sleep elevated, with more than one pillow	☐ Sinus congestion/ pain/ fullness	☐ Nasal congestion
☐ Coughing	☐ Shortness of breath	☐ Wheezing
☐ Loss of pleasure in usual activities	☐ Anxiety	☐ Depression
☐ Suicidal thoughts	☐ Confusion	☐ Memory problems
☐ Frequent urination	☐ Decreased interest in sex	☐ Heartburn
☐ Abdominal pain	☐ Loss of appetite	☐ Nausea
☐ Abdominal bloating	☐ Diarrhea	

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Name:

Please select any surgeries that you have had and indicate in what year the surgery was performed:

☐ Tonsillectomy/Adenoidectomy in: _____ ☐ UPPP in: _____ ☐ Nasal Surgery in: _____ ☐ Jaw Surgery in: _____

Please list other surgeries and year performed: _____

Check any conditions that you (Me) or a parent/ sibling/ child (F) have been diagnosed with:

Me	F		Me	F		Me	F	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Post-Traumatic Stress Disorder
☐	☐	Atrial Fibrillation	☐	☐	Congestive Heart Failure (CHF)	☐	☐	High Blood Pressure (HTN)
☐	☐	COPD	☐	☐	Asthma	☐	☐	Stroke
☐	☐	Acid-Reflux Disease (GERD)	☐	☐	Diabetes Mellitus (Type 1 or 2)	☐	☐	Thyroid disorder
☐	☐	Fibromyalgia	☐	☐	Seizures (Epilepsy)	☐	☐	Traumatic Brain Injury
☐	☐	Seasonal Allergies	☐	☐	TMJ Pain	☐	☐	Restless Leg Syndrome
☐	☐	Obstructive Sleep Apnea	☐	☐	Narcolepsy			

Please list other medical conditions for which you are currently receiving (or have received) treatment for: _____

You may email an encrypted copy of this intake form to usarmy.bragg.medcom-wamc.mbx.sleep-disorders-clinic@mail.mil or bring a printed copy to your appointment.