Sleep History

SweetLife®
Diabetes Health Centers

ROOT CAUSE ASSESSMENT FORM

How many hours of sleep do you average per night?

_____ < 5 _____ 5 - 7 _____ 7 - 9 _____ 9 - 11 _____ > 11

Do you have trouble falling asleep? _____ never _____ sometimes _____ mostly _____ always

Do you have trouble staying asleep? _____ never _____ sometimes _____ mostly _____ always

Do you feel rested upon waking? _____ yes _____ no

Do you have sleep apnea or snore? _____ yes _____ no If so, describe: _____

Do you use sleeping aids? _____ yes _____ no If so, describe: _____

What have you tried to improve your sleep? _____

_____