UPDATED 09/2008

Sleep and Medical History Questionnaire

Name: ______________________ Age: ________ Primary MD: ________________

SSN: ________________ Height: ______ Weight: ______ Referring MD: ________________

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions **as thoroughly as you can.**

*****All answers should refer to a typical night (or day) of sleep.*****

***** If you are already using CPAP, answer according to when you are wearing the mask.*****

Annotate your main problem(s):

( ) Act out dreams ( ) Hard to fall asleep ( ) Hold breath when sleeping ( ) Snore ( ) Too tired
( ) Gasp or Choke ( ) Hard to stay asleep ( ) Legs kick/move ( ) Too sleepy ( ) Usually feel un-rested
( ) Other: ____

General Sleep:

1. For how long have you had this problem?
   ( ) Only within the last month ( ) 1-6 months ( ) 6 months – 2 years ( ) > 2 years

2. Rate the severity of your problem.
   ( ) Mild ( ) Moderate ( ) Severe ( ) the problem is only for others

3. Is it getting worse?
   ( ) No ( ) Yes ( ) Do not know

5. Does your sleep problem negative impact ….your work performance? ( ) No ( ) Yes
   ….your sex life? ( ) No ( ) Yes
   ….your quality of life? ( ) No ( ) Yes
   ….your social activity? ( ) No ( ) Yes

6. Do any other members of your family have significant sleep problems? ( ) No ( ) Yes
   If yes, please explain:____

7. Do you use any medication or other substance to help you sleep? ( ) No ( ) Yes
   If yes, please list name, dose, frequency, length of usage:________________________

8. Have you ever discussed these sleep problems with another doctor?

   ( ) No ( ) Yes… Dr. name: ____________Diagnosis:______________________

   List present sleep treatment: ______________________ date started:____________

   List prior sleep treatment: ______________________ dates:____________

N = Never O = Occasionally F = Frequently

Please rate how often ***<u>you or others</u>*** have noted that you:

Item	N	O	F
Snore	N	O	F
Snore loudly enough that others complain	N	O	F
Awaken from sleep feeling short of breath, gasping, or choking	N	O	F
Hold your breath or stop breathing while asleep	N	O	F
Experience other breathing problems at night	N	O	F
Have headaches upon waking that improve in less than 2 hours	N	O	F
Have dry mouth upon waking	N	O	F
Sweat excessively at night	N	O	F
Experience heart pounding or beating irregularly during the night	N	O	F

Item	N	O	F
Feel sleepy or tired during the day	N	O	F
Awaken feeling unrested or unrefreshed	N	O	F
Get sleepy while driving	N	O	F
Have had a wreck due to sleepiness	N	O	F
Have trouble at work or school because of sleepiness	N	O	F
Become irritable or "crabby"	N	O	F
Experience decrease in memory or concentration abilities	N	O	F

(DOCTOR ONLY)

ESS=____

Prtnr=____

Item	N	O	F
Fall asleep involuntarily or suddenly or in awkward situations	N	O	F
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying	N	O	F
Feel totally unable to move (paralyzed) when first waking or falling asleep	N	O	F
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep (similar to hallucinations)	N	O	F
Find yourself doing complex tasks of which you were totally unaware (such as driving/navigating without conscious awareness)	N	O	F

Item	N	O	F
Have nightmares or night terrors	N	O	F
Act out your dreams	N	O	F
Walk in your sleep	N	O	F
Do anything else considered "unusual" while asleep	N	O	F

Item	N	O	F
Recurrently or rhythmically move, twitch or jerk your legs **<u>while asleep</u>**	N	O	F
Feel restlessness, agitation or discomfort in your legs **<u>at or before bedtime</u>**	N	O	F

If so…..

Question	No	Yes
Do you feel an overwhelming urge to move your legs?	( ) No	( ) Yes
Does it happen only in the evening?	( ) No	( ) Yes
Does it happen only when relaxed?	( ) No	( ) Yes
Does it get better if you move about or walk?	( ) No	( ) Yes
Does it disturb sleep or sleep onset?	( ) No	( ) Yes

How often do you experience this? ___________days per **<u>week</u>** or **<u>month</u>** *(circle one)*

Sleep Hygiene:

1. Do you often have anxiety (worry about things) around bedtime? ( ) No ( ) Yes
2. Do you often feel sad or depressed? ( ) No ( ) Yes
3. Do you sleep better away from home than in your own bed? ( ) No ( ) Yes
4. Do you have thoughts racing through your mind while trying to go to sleep? ( ) No ( ) Yes
5. Do you get anxious or upset when you are unsuccessful with falling asleep? ( ) No ( ) Yes
6. Do you usually take coffee, tea, or chocolate within 2 hours before you go to bed? ( ) No ( ) Yes
7. Do you do physical exercise within 2 hours before bedtime? ( ) No ( ) Yes
8. Do you watch TV or read in bed before falling asleep? ( ) No ( ) Yes
9. Do you ever sleep, nap, or rest during the awake portion of your day? ( ) No ( ) Yes

   If yes… how often? ___________ # per day ____________ total per week

   …on average, how long is your nap? ( ) less than 1 hr ( ) 1 hr or more

   …after a nap do you still remain tired? ( ) No ( ) Yes
10. Check any condition that routinely applies to you:

    ( ) sleep with someone else in your bed ( ) sleep with a pet in your room ( ) sleep by yourself
    ( ) provide assistance to someone during the night (child, invalid, bed partner, animal)
11. Check any factors that disturb your sleep:

    ( ) heat ( ) cold ( ) light ( ) noise ( ) bed partner ( ) other: _________________

Sleep Habits:

12. You feel your best during ( ) Morning ( ) Afternoon ( ) Evening
13. Estimate your total **actual sleep per night?** (do not include time awake in bed) ______________________
14. What time do you **usually go to bed?** **on WORKDAYS?** ___________ **on NON-WORKDAYS?** ____________
15. What time do you **usually rise from bed?** **on WORKDAYS?** ___________ **on NON-WORKDAYS?** ____________
16. How long does it **usually** take you to **fall asleep**? ____
17. How many hours of sleep do you feel you **need** in order to feel your very best? ______________________
18. In a perfect world, what would be your choice for an **ideal hour** to go to bed? _____________ To awaken? ____________
19. In your opinion, what usually **prevents** you from quickly falling to sleep? ____
20. How many times do you **typically wake up** at night? ____________________Cause?____
21. If you wake up, **on the average,** how long do you **stay awake?** ____
22. If you do awaken during the night, in which part(s) of your sleep period is it predominantly?
    ( ) soon after falling asleep ( ) middle of the night ( ) near end of sleeping period

Current Medications:

****Please list all medicines prescribed by your doctor and their dosages****

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

MEDICAL HISTORY

Past Medical History:

[Please check any condition that a *doctor has diagnosed* you with:]

Cardiac/Heart: (C:)	**Digestive**: (D:)	**Endocrine/Other:** (E:)	**Lung/Pulmonary:** (L:)	**Neurology:** (N:)	**Psychology**: (P:)
[ ] Anemia	[ ] Acid reflux (GERD)	[ ] Arthritis/chronic pain	[ ] Asthma	[ ] Headache	[ ] Alcoholism
[ ] Angina	[ ] Diverticulitis	[ ] Back pain	[ ] Bronchitis	[ ] Infection of brain/ spinal cord	[ ] Drug abuse
[ ] CHF (heart failure)	[ ] Hiatal hernia	[ ] Chronic fatigue syn	[ ] COPD	[ ] Injury of brain/spinal cord	[ ] Depression
[ ] Elevated lipids (cholest.)	[ ] other digestive probs	[ ] Fibromyalgia	[ ] Emphysema	[ ] Nerve damage	[ ] Suicide attempt
[ ] Heart attack		[ ] Diabetes	[ ] other Lung probs.	[ ] Seizure/epilepsy	[ ] Anxiety
[ ] High blood pressure		[ ] Thyroid disease		[ ] other Brain/Nerve disorders	[ ] Panic attacks
[ ] Stroke		[ ] Sickle cell			[ ] OCD
[ ] Other heart problem		[ ] Kidney disease			[ ] ADD/ADHD
		[ ] Cancer			

[ ]Other____

Medication Allergies:

[Are you allergic to any medications? (Please list)]

__________________________ ______________________________ ______________________________

Past Surgical History:

[Please list any operations and approximate date of surgery.]

Date	Type of Surgery	Date	Type of Surgery
_________	____________________	________	_____________________________
_________	____________________	________	_____________________________

Family History:

[Has anyone in your *blood-related* family ever been afflicted with:]

☐ Acting out dreams	☐ Excessive sleepiness	☐ Narcolepsy	☐ Sleep walking
☐ Depression	☐ Heart attack	☐ Restless legs	☐ Stroke
☐ Diabetes	☐ Hypertension	☐ Sleep apnea	☐ Suicide

Social History:

Marital Status: S M D W Occupation: _____________________________________

[Please check all that apply:]

Children at home	☐ None	☐ Grown/gone	☐ Yes: ages _______________		
Others at home	☐ None	☐ Spouse	☐ Friend	☐ Parents/grandparents	☐ other
Alcohol	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Alcoholic
Tobacco	☐ None	☐ Yes – type _______________________		How much ___________________	
Recreational drugs	☐ None	☐ Yes – type _______________________		Frequency ___________________	

Other:

Personal assessment of current health: Poor__ Fair__ Good__ V.Good__ Excellent__

Weight gain in the past 12 months: None_____ amt:_____lbs

Weight loss in the past 12 months: None_____ amt:_____lbs

Most you have *EVER* weighed *(non-pregnant)*: ________lbs In what year? _______

(DOCTOR ONLY)

Today:
_______lbs

REVIEW OF SYSTEMS

[Do you presently, or have you in the recent past, suffered from any of the listed items? (check all that apply)]

Constitutional
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight Loss

Eyes
- ☐ Pain
- ☐ Visual changes
- ☐ Discharge
- ☐ Double vision

Ear, Nose, Throat and Allergy
- ☐ Trouble breathing through nose
- ☐ Night time congestion
- ☐ Trouble swallowing
- ☐ Hoarse voice
- ☐ Frequent nosebleed
- ☐ Swollen glands
- ☐ Frequent infections
- ☐ Frequent hives
- ☐ Frequent colds
- ☐ Nasal/Seasonal allergies

Heart
- ☐ Chest pain while awake
- ☐ Chest pain while asleep
- ☐ Very rapid heart beat
- ☐ Irregular heartbeat
- ☐ Leg swelling
- ☐ Pains in legs when walking

Lungs
- ☐ Chronic cough
- ☐ Cough up blood
- ☐ Pain with breathing
- ☐ Short of breath w/mild exertion
- ☐ Trouble breathing laying flat

Digestive
- ☐ Frequent nausea/vomiting
- ☐ Frequent indigestion
- ☐ Frequent diarrhea/constipation
- ☐ Frequent bloating
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain

Genital/Urinary
- ☐ Blood in urine
- ☐ Frequent nighttime urination

MALE: ☐ Trouble with erection
- ☐ Testicular pain or swelling

FEMALE :☐ Irregular periods
- ☐ No period any longer

Musculoskeletal
- ☐ Joint pain or swelling
- ☐ Back pain (chronic)
- ☐ Muscle pain or weakness
- ☐ Leg cramps

Nervous System
- ☐ Frequent headaches
- ☐ Loss of strength in specific body area
- ☐ Loss of feeling in specific body area
- ☐ Fainting spells
- ☐ Trouble with balance
- ☐ Trouble with coordination
- ☐ Dizziness
- ☐ Trouble walking

Psychiatric
- ☐ Hallucinations
- ☐ Nightmares
- ☐ Feel depressed
- ☐ Feel nervous or tense
- ☐ Suicidal thoughts

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hot flashes
- ☐ Urinating frequently

FOR DOCTOR USE ONLY

- ☐ Rest of Review of Systems is otherwise negative
- ☐ Entire Questionnaire reviewed with patient this date ________________________

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