MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ SEX:_____ DATE: _____

DOB: _____ AGE: _____ Primary Doctor / Care Manager: _____

Additional doctors to receive sleep study results: _____

Chief sleep related complaint: _____

What made you decide to have this problem evaluated? _____

How do problems with sleep affect your quality of life? _____

Have you ever had a sleep study before? _____ When? _____Where? _____

USE THIS SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading	_____
Watching TV	_____
Sitting in a public place for example, a theatre 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 (when you have had no alcohol)	_____
In a car, while stopped in traffic	_____

SELECT ALL THAT APPLY

___ **Snoring** [Mild - Moderate – Loud - On my back - All positions]
___ **I wake up** [Choking - Coughing - Gasping - Smothering - Snoring - Sweating]
___ **Told I stop breathing in my sleep** [Spouse – Partner – Family – Friends]
___ **I disturb my bed partner** [Sometimes - Most nights]
___ **We sleep in different rooms** [Sometimes - Most nights]
___ **Get up to go to the bathroom** [0 - 1 – 2 – 3 – Multiple] times each night
___ **Heart** [RACING – POUNDING – PALPITATIONS] at night
___ **Restless sleep**
___ **Morning dry mouth or sore throat**
___ **Morning headaches** [Daily – Occasional]
___ **I wake up feeling** [Refreshed – Tired – Worse than the night before]
___ **I sleep through my alarm.**
___ **I have trouble getting to work on time.**
___ **During the day, I feel** [Tired, Fatigued, Sleepy, Exhausted)
___ **I have trouble staying awake** [Driving – Work – Meetings – Reading – Watching TV]
___ **I struggle with** [Memory – Attention – Concentration – Judgment – Motivation]
___ **My mood is** [Depressed – Irritable – Anxious – Angry]
___ **I can drive for miles and not realize how I got somewhere**
___ **I drink** [Coffee – Tea –Sodas – Energy Drinks] [_____ cups/drinks per day]
___ **I nap** [Daily – Weekends] [_____ times per week].

How long have you had these symptoms? _____

SLEEP HABITS

What time do you get into bed? Weekdays _____ Weekends _____
What time do you get out of the bed? Weekdays _____ Weekends _____

What is your typical sleeping position? [Back - Side – Stomach – Recliner]
What is the setting of your thermostat? _____ degrees
How many hours do you sleep on the average night? _____
How many hours do you spend napping on the average day? _____
With whom do you share the bedroom? [Spouse - Partner – Children – Pets]
Which best describes you? [Night owl – Morning person]

Pre-sleep routine (Select all that apply)

___ **I watch TV** [In the bedroom - In another room – Both]
___ **The TV is on all night**
___ **I read** [In the bedroom – In another room – Both]
___ **I spend time on the computer**
___ **I play video games**
___ **I spend time on work or studying**
___ **I exercise within 3 hours of bed**
___ **I drink alcohol** [Beer – Wine – Liquor – Every Night - ____ Nights per week]
___ **I shower or bathe**

INSOMNIA (SELECT ALL THAT APPLY)

___ **I have trouble falling asleep** [_____ Nights per week – Every night]
___ **I have trouble staying asleep**
___ **I wake up early in the morning and can't go back to sleep**
___ **I can tell when I am not going to be able to fall asleep**
___ **I worry about being unable to fall asleep**
___ **I worry about the consequences of lack of sleep**
___ **Thoughts are racing through my mind when I try to go to sleep**
___ **I have increased muscle tension at night**
___ **I am unable to fall asleep without taking medication**
___ **I have more trouble sleeping** [At home – Hotels – Vacation – Travel]
___ **I have trouble sleeping at night if I nap during the day**
___ **I get up to eat at night**
___ **I watch the alarm clock at night**

When did this problem start? _____
How long does it take you to fall asleep? _____
What do you do if you cannot fall asleep? _____
How many times do you wake up each night? _____
If you wake up, how long does it take you to return to sleep? _____
Is there anything about your bed partner or sleeping environment that interferes with your sleep?
_____
How many days per week do you take medication for sleep? _____
What is your current sleep medication? _____
What time do you take the medication? _____
How long does it take the medication to work? _____
Have you ever had a bad reaction to a sleep medication? _____
Have you ever seen a psychologist for treatment of insomnia? _____

MOVEMENT DISORDERS (SELECT ALL THAT APPLY)

___ **Before sleep, I have an urge to move my legs or arms**
___ **My legs or arms feel uncomfortable** [Tight – Restless – Tingle – Crawling sensation]
___ **Movement of the limbs causes a sense of relief**
___ **These symptoms start or get worse at night or in the evening**
___ **At times, I am unable to hold still when sitting in a chair or lying in bed**.
___ **My legs or arms continue to move or jerk during sleep.**
___ **I have a history of iron deficiency or anemia**
___ **I donate blood** [How often? _____]

What time does the restlessness or discomfort in the legs start? _____
How long have you had this movement problem? _____
How many nights per week? _____
Are symptoms made worse by [Caffeine – Alcohol – Medications – Exercise]
Have you taken medication to treat these symptoms? _____

___ **Just as I am falling asleep, my muscles jerk**
___ **I grind or clench my teeth during sleep**
___ **I wear a mouth guard** (bite splint)

BEHAVIOR IN SLEEP (SELECT ALL THAT APPLY)

___ **Sleepwalking** [Childhood – Currently – Ambien]
___ **I get up to eat during sleep, and I don't remember doing it.**
___ **I talk in my sleep**
___ **I suddenly rouse from sleep with panic and confusion**
___ **I have bad dreams or nightmares** [_____ Nights per week – Nightly]
___ **I physically act out what I am dreaming about**
___ **I have hurt myself or my bed partner during sleep**
___ **I do not remember my dreams**
___ **I have other abnormal behavior at night** _____

How long have you had this abnormal behavior? _____
Have you ever been treated for this condition? _____

NARCOLEPSY AND DISORDERS OF SEVERE SLEEPINESS (SELECT ALL THAT APPLY)

___ **I have sleep attacks where I fall asleep without warning or against my will**
___ **Short naps (less than 30 minutes) are refreshing**.
___ **When struck by a sudden emotion** [Laughter – Excitement – Anxiety], **my muscles become weak.** [Drop things – Collapse – Weak in the knees – Face feels weak – Hands feel weak – I have trouble talking – I lean against the wall – I sit down]
___ **I feel paralyzed or unable to move when falling asleep or when waking up.**
___ **I visually hallucinate or see things in the room when I am falling asleep or when I wake from sleep.**
___ **I routinely dream during naps.**
___ **No matter how long I sleep, I never feel rested or fully awake**.

How old were you when these symptoms started? _____
Have you ever had an accident as a result of falling asleep while driving? _____
Have you ever taken medication to treat these symptoms? _____

CIRCLE ALL MEDICATIONS THAT YOU HAVE PREVIOUSLY TRIED FOR SLEEP:

Ambien/zolpidem	Ambien CR/zolpidem ER	Intermezzo	Lunesta/ eszopiclone	
Sonata/zaleplon	Seroquel/quetiapine	Silenor	Rozerem	Edluar
Restoril/temazepam	Desyrel/trazodone	Melatonin	Valerian	Other
Remeron/mirtazepine	Elavil/amitriptyline	Tylenol Pm	Benadryl	

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS OR PROVIDE LIST

Pharmacy: _____

NAME of Medication	DOSE	FREQUENCY

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

___ High Blood Pressure
___ Heart Disease
___ Arrhythmia
___ Diabetes
___ High cholesterol
___ Stroke
___ TIA
___ Asthma (Childhood) (Current)
___ COPD / Emphysema
___ Nasal Allergies (seasonal) (all year)
___ Sinus Infections ___ times/year
___ Strep Throat ___ times/year
___ Acid Reflux / Heartburn
___ Stomach Ulcer
___ Liver Disease
___ Colon Disease / Hemorrhoids
___ Anemia
___ Cancer (Type:_____)
___ Kidney Disease
___ Prostate Disease

____ Post Traumatic Stress Disorder
____ Anxiety Disorder
____ Depression
____ Bipolar Disorder
____ Thyroid Disease
____ Menopause
____ Pregnancy
____ Migraine
____ Neuropathy
____ Epilepsy / Seizures
____ Head Injury / TBI
____ Fibromyalgia
____ Chronic Pain
____ Arthritis
____ (Alcohol) (Drug) (Medication) Addiction
____ ADD/ ADHD
____ Additional :
____ _____
____ _____
____ _____

WHAT DRUGS ARE YOU ALLERGIC TO?

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

PAST SURGICAL HISTORY

___ Weight loss surgery
___ Tonsillectomy
___ Sinus Surgery
___ Septoplasty
_____
_____

ADDITIONAL SURGERIES
_____
_____
_____
_____
_____

FAMILY HISTORY (CHECK ALL THAT APPLY)

Members	Living or Deceased	Sleep Apnea	Insomnia	Restless Legs	Narcolepsy	Sleep Walking	High Blood Pressure	Stroke	Heart Disease	Diabetes
Father										
Mother										
Brother(s)										
Sister(s)										
Son(s)										
Daughter(s)										

Other significant family history: _____

SOCIAL HISTORY

Do you smoke? _____ How much? _____ How long?_____ When did you quit? _____
Do you drink alcohol? _____ How much? _____ How often? _____
Do you have any history of drug use? _____ What? _____
___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
___ Employed ___ Unemployed ___ Retired ___ Part time

What is/was your occupation? _____

___ My job requires me to drive
___ Shift work (Permanent Night Shift) (Rotating Shifts) Which Shift _____
___ I am currently a student

EDUCATION: (High School) (College) (Postgraduate) (Other)

IN THE PAST 12 MONTHS HAVE YOU HAD – PLEASE CIRCLE ALL THAT APPLY							
GENERAL	change in appetite	weight loss	weight gain	fatigue	stress	fever	shaking chills
EYES	loss or blurring of vision	double vision	floaters in vision	dry eyes			
EARS	hearing loss	ringing in the ears	sensation of spinning or balance difficulty	ear infection			
NOSE	nose bleeds	nasal congestion	sinus infection, pressure, or pain	postnasal drip			
THROAT	sore or infected throat	change in voice or speech	trouble swallowing				
CARDIO	chest pain or pressure	palpitations	swelling in the legs and feet	fainting			
PULM	cough	shortness of breath	wheezing	painful or uncomfortable breathing			
GI	heartburn	nausea	vomiting	stomach pain	diarrhea	constipation	blood in stool
GU	frequent urination	urgent urination	blood in urine	incontinence	sexual dysfunction		
HEME	swollen lymph nodes	easy or excessive bruising	blood loss	anemia or low blood counts			
ENDO	heat intolerance	cold intolerance	swelling at the base of the neck	increased thirst			
DERM	rash	dry or itchy skin	hives or whelps	hair loss			
ORTHO	neck pain	back pain	joint pain	joint swelling	trauma to bones or skull fracture		
NEURO	headache	trouble walking	muscle weakness	loss of sensation or feeling	tremor		
PSYCH	depression	anxiety	panic attack	suicidal thoughts	hallucinations	mania	