MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ SEX:____ DATE: _____

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

Pharmacy Name/Address: _____

Pharmacy Phone #: _____

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 AND CIRCLE 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	⊙0 ○1 ○2 ○3
Watching TV	⊙0 ○1 ○2 ○3
Sitting in a public place for example, a theatre or meeting	⊙0 ○1 ○2 ○3
As a passenger in a car for an hour without a break	⊙0 ○1 ○2 ○3
Lying down to rest in the afternoon	⊙0 ○1 ○2 ○3
Sitting and talking to someone	⊙0 ○1 ○2 ○3
Sitting quietly after lunch (when you have had no alcohol)	⊙0 ○1 ○2 ○3
In a car, while stopped in traffic	⊙0 ○1 ○2 ○3

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)

- [x] **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) --- CHECK N/A IF NONE APPLY: ☐ N/A

- [ ] **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)- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **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)--- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **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 -- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **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 ☐	AmbienCR/zolpidemER ☐	Intermezzo ☐	Lunesta ☐	Edluar ☐
Sonata/zaleplon ☐	Seroquel/quetiapine ☐	Silenor ☐	Rozerem ☐	Belsomra ☐
Restoril/temazepam ☐	Desyrel/trazodone ☐	Melatonin ☐	Valerian ☐	Other ☐
Remeron/mirtazepine ☐	Elavil/amitriptyline ☐	Tylenol Pm ☐	Benadryl ☐	

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS OR PROVIDE A COPY OF YOUR LIST.

NAME of Medication	DOSE	FREQUENCY

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)-- CHECK N/A IF NONE APPLY: ☐ N/A

- ☐ 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 :

- ☐ _____
- ☐ _____