SLEEP & MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ Sex_____ Age_____ Date_____

Please complete the following questionnaire by placing a check in the appropriate areas and filling in the blanks.

My Main Sleep Complaint(s) Is:

___ Trouble sleeping at night for how many months/years? _____

___ being sleepy all day for how many months/years? _____

___ snoring for how many months/years? _____

___ unwanted behaviors during sleep, explain _____

___ other, explain _____

Sleep Pattern:

	Weekdays(Work Days)	Weekends(Off Days)
Typical bedtime:	_____	_____
Typical time required to fall asleep:	_____	_____
Type of activities done during nighttime awakenings (restroom, TV, read, eat):	_____	_____
Typical time required to fall back asleep after awakening:	_____	_____
Typical wake up time:	_____	_____
Desired wake up time:	_____	_____
How do you usually awaken (alarm clock, pets, bed partner):	_____	_____
Typical time you get up:	_____	_____
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

Please check all of the following statements that are true about your sleep:

Sleep Habits

I usually sleep alone: ____ , or I sleep with ___ a partner ___ pets ___ children

____ I share a bedroom, but have separate beds

____ I share a dwelling, but have separate bedrooms

____ My sleep disturbance is problematic to my relationship with my bed partner

____ My sleep disturbance affects my bed partner's sleep

____ I usually watch TV or read in bed prior to sleep

____ I frequently travel across two or more time zones

____ I drink alcohol prior to bedtime

____ I drink caffeinated beverages in the evening

____ I smoke prior to bedtime or when I awaken during the night

____ I eat a snack at bedtime

____I eat if I awaken during the night

____ I typically awaken to urinate during the night

____ I have trouble falling asleep

____ I awaken frequently during the night

____ I am unable to return to sleep easily if I awaken during the night

____ Thoughts start racing through my mind when I try to fall asleep

____I awaken early in the morning, still tired but unable to return to sleep

____ I have nightmares as an adult

____ I experience a creeping-crawling, or tingling sensation in my legs when I try to fall asleep

____ I sweat a great deal during sleep

____ I cannot sleep on my back

Breathing

____ I have been told that I stop breathing while I sleep

____ I awaken at night choking, smothering, or gasping for air

____ I have been told that I snore

____ I have been told that I snore only when sleeping on my back

____ I have been awakened by my own snoring

Restlessness

____ I am a restless sleeper

____ I kick or jerk my legs and/or arms when I sleep

____ I experience restlessness, tingling, or crawling in my arms or legs

____ I experience an inability to keep my legs still prior to falling asleep

____ I talk in my sleep as an adult

____ I have sleep walked as an adult

____ I grind my teeth in my sleep

Daytime Sleepiness

____ I take daytime naps

____ I have a tendency to fall asleep during the day

____ I have experienced lapses in time or blackouts

____ I have fallen asleep while driving

____ I have had an auto accident as a result of falling asleep while driving

____ I have had an accident while operating heavy machinery or equipment as a result of falling asleep

____ I have had injuries as a result of sleepiness

____ I fall asleep while watching TV

____ I fall asleep during conversations

____ I fall asleep in sedentary situations

____ I performed poorly in school because of sleepiness

____ I have experienced sudden muscle weakness in response to emotions such as laughter, anger, or surprise

____ I have experienced an inability to move while falling asleep or waking up

____ I have experienced hallucinations, dreamlike images, or sounds while falling asleep or waking up

Medical History

What is your: Height? _____ Weight? _____

What was your weight one year ago? _____ Five years ago? _____

For women:

Pregnant? ___ Yes __ No If yes, due date? _____

Any pregnancy complications? ____ Describe _____

_____

_____

Complications in previous pregnancies? ____ Describe _____

_____

_____

Premenopausal __ Birth Control? ___ Describe _____

Are your cycles fairly regular ___ Yes __ No

Postmenopausal ___ Hormone Replacement? ___ Describe _____

_____

Bioidentical Hormones ___ Describe _____

_____

Past Sleep Evaluation & Treatment:

____ I have had a previous sleep disorder evaluation

____ I have had a previous overnight sleep study

____ I have had daytime nap studies

____ I have been prescribed a CPAP or bi-level machine for home use

____ I have had surgical treatment for a sleep disorder

____ I have previously been treated for a sleep disorder

____ I have previously been prescribed medication for a sleep disorder

Please list the name of any pill that you have taken in the past for a sleeping disorder, i.e. insomnia, daytime drowsiness, restless legs:

Name	Did it help?	
_____	Yes ___	No ___
_____	Yes ___	No ___

General Medical History:

____ Anemia

____ Abnormal bleeding

____ Fibromyalgia

____Arthritis

____ Anxiety

____Depression

____ Post Traumatic Stress Disorder

____ Asthma/COPD/emphysema

____ Bronchitis

____ Allergies/Hay fever

____Congenital defect/disorder

_____Alcoholism

____ Drug dependence

____ Migraine

____ Seizures

____ Heart attack

____ Heart Disease/Failure

____ Heart Arrhythmia

____ High Blood Pressure

____ High cholesterol

____ Chest pain

____ Dizziness/fainting

____Diabetes

____ Stroke

____ Cancer

____ Parkinson's Disease

____ Prostate disease

____Urinary disorder

____ Gynecologic disorder

____ Other (describe below)

____ Hepatitis

____ Liver diseases

____ Reflux/Ulcer

____ Thyroid disease

____ Positive TB skin test

____ Tuberculosis

____ Valley Fever

_____

_____

Surgical History: *List surgeries and year*

_____ _____

_____ _____

Family History: *Please check all that apply and indicate who was affected*

Sleep Apnea	____	_____
Obesity	____	_____
High Blood Pressure	____	_____
Heart Attack	____	_____
Stroke	____	_____
Diabetes	____	_____
Insomnia	____	_____
Anxiety/Depression	____	_____
Thyroid Disease	____	_____
Narcolepsy	____	_____
Restless Legs	____	_____
Bleeding Disorder	____	_____
Sleepwalking	____	_____
Epilepsy	____	_____
Cancer (type)	____	_____

Social History:

Marital Status:
____ single ____ married ____ divorced ____ separated ____ widowed

Occupation _____

Do you operate heavy machinery or dangerous equipment at work or involving a hobby or sport? ____ yes ____ no

Do you fly an airplane? ____ yes ____ no

Are you a commercial: ____ truck driver ____ pilot ____ train operator
____ tractor/crane/forklift, etc. operator

Sports/Hobbies _____

Exercise routine/frequency _____

Have you ever smoked? ____ yes ____ no
If you quit, when? _____ # years smoked ____ #packs/day ____

Do you currently smoke? ____ yes ____ no
if yes, ____ cigarettes ____ cigars ____ pipe
amount per day _____ #years ____

Do you drink alcohol?	____ yes	____ no	
if yes, what type?	____ beer	____ wine	____ hard liquor
#drinks/day	____	____	____
#drinks/week	____	____	____
#drinks/month	____	____	____

Do you use recreational drugs? ____ previously ____ currently
describe _____
_____

Caffeine Use:	____ coffee/tea	____ soda	____energy drinks
drinks per day	____	____	____

Medications:

Name Strength(i.e. mg) Frequency(i.e. every morning)

_____
_____
_____
_____
_____
_____
_____
_____

Allergies :

Type (i.e. name of drug, environmental, latex, peanuts) Reaction (rash, swelling)

_____
_____
_____
_____
_____