

SLEEP & MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____ Height: _____ Weight: _____

USUAL SLEEP HABITS:

Bedtime: _____ Number of times awake to urinate at night _____
Wake time: _____ Number of naps/week _____ Number of awakenings _____

DIRECTIONS: Check any statement which currently applies to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> un-refreshing naps | <input type="checkbox"/> very loud snoring | <input type="checkbox"/> awaken with choking sensation |
| <input type="checkbox"/> restless sleeper | <input type="checkbox"/> stop breathing during sleep | <input type="checkbox"/> awaken with headaches |
| <input type="checkbox"/> have high blood pressure | <input type="checkbox"/> vivid dreams | <input type="checkbox"/> difficulty waking in the morning |
| <input type="checkbox"/> gained >10 lbs in last year | <input type="checkbox"/> daytime sleepiness | <input type="checkbox"/> falling asleep at inappropriate times |
| <input type="checkbox"/> unable to sleep in a flat position | <input type="checkbox"/> refreshing naps | <input type="checkbox"/> driving accidents or near accidents due to sleepiness |
| <input type="checkbox"/> dream excessively | <input type="checkbox"/> eat excessive sweets or chocolate | <input type="checkbox"/> dreams or hallucinations while awake |
| <input type="checkbox"/> trouble falling asleep | <input type="checkbox"/> awaken long before it is necessary | <input type="checkbox"/> paralysis or inability to move on awakening |
| <input type="checkbox"/> sleep better in unfamiliar setting | <input type="checkbox"/> kicking or twitching during sleep | <input type="checkbox"/> sudden feeling of weakness in legs or knees |
| <input type="checkbox"/> light sleeper | <input type="checkbox"/> function best in the evening | <input type="checkbox"/> feel a creeping or crawling sensation in legs |
| <input type="checkbox"/> legs jerk during sleep | <input type="checkbox"/> inability to keep legs still | <input type="checkbox"/> hyperactive as a child or teenager |
| <input type="checkbox"/> sleep with ear plugs or eyeshades | <input type="checkbox"/> trouble returning to sleep | <input type="checkbox"/> don't feel tired at bedtime |
| <input type="checkbox"/> use sleeping pills | <input type="checkbox"/> bed partner disturbs sleep | <input type="checkbox"/> grind teeth in sleep |
| <input type="checkbox"/> jaws ache in the morning | <input type="checkbox"/> sleep walking as an adult | <input type="checkbox"/> bedwetting in adulthood |
| <input type="checkbox"/> sleep talking as an adult | <input type="checkbox"/> shift worker or night worker | <input type="checkbox"/> banging, twisting, or shaking of the head in sleep |
| <input type="checkbox"/> late sleeper | <input type="checkbox"/> heart pain during the night | <input type="checkbox"/> sudden awakening with intense anxiety |
| <input type="checkbox"/> nighttime seizures | <input type="checkbox"/> awaken with back pain | <input type="checkbox"/> bitter or sour mouth taste in morning |
| <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> awaken with blood on the pillow | <input type="checkbox"/> awaken with heartburn |

Your Past Medical History (check if you have had)

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> German measles | <input type="checkbox"/> mumps | <input type="checkbox"/> chicken pox | <input type="checkbox"/> arthritis or rheumatism |
| <input type="checkbox"/> neuritis, neuralgia | <input type="checkbox"/> stroke or paralysis | <input type="checkbox"/> whooping cough | <input type="checkbox"/> diphtheria | <input type="checkbox"/> severe back pain or spasm |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> bursitis | <input type="checkbox"/> migraine headaches | <input type="checkbox"/> severe neck pain or spasm |
| <input type="checkbox"/> seizures or epilepsy | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> severe dizzy episodes | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> suicide attempt | <input type="checkbox"/> anemia | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> concussion, head injury |
| <input type="checkbox"/> angina, chest pain | <input type="checkbox"/> hepatitis or jaundice | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> heart palpitations |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> psychiatric treatment | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> sinusitis | <input type="checkbox"/> drug/alcohol addiction |
| <input type="checkbox"/> gonorrhea/syphilis | <input type="checkbox"/> prostate problems | <input type="checkbox"/> polio | <input type="checkbox"/> loss of vision | <input type="checkbox"/> severe menstrual problems |
| <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> colitis | <input type="checkbox"/> gout | <input type="checkbox"/> food, drug, chemical poisoning |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart failure | <input type="checkbox"/> asthma or hay fever | <input type="checkbox"/> emphysema | <input type="checkbox"/> psychiatric hospitalization |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> cancer or tumors | <input type="checkbox"/> other lung diseases | <input type="checkbox"/> broken bones | <input type="checkbox"/> psoriasis |

Sleep

Complaint(s): _____

Has a spouse/roommate/etc noticed any of the following sleep behaviors from you?

- _____ Loud Snoring
- _____ Light Snoring
- _____ Twitching of Legs or Feet During Sleep
- _____ Kicking with Legs during Sleep
- _____ Pauses in Breathing
- _____ Grinding Teeth
- _____ Sleep Talking
- _____ Sleepwalking
- _____ Bed Wetting
- _____ Sitting Up or Getting Out of Bed But Not Awake
- _____ Becoming Very Rigid and/or Shaking

How long have you been aware of the sleep behavior(s) checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, its frequency during the night, and whether it occurs every night.

If you heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"? _____

List any surgeries you have had:

Type of Surgery	How Long Ago (years)
_____	_____
_____	_____

Cigarette Smoker: Y N If yes: _____ pack(s)\day

Alcohol Consumption: Y N If yes, how often: _____

<u>MEDICATION</u>	<u>HOW MUCH</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____