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Patient ID Label

Patient Medical and Sleep History Questionnaire

please complete all questions

Patient Name: _____ DOB: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Height: _____ft _____ in Weight: _____ lbs Year of Last Physical Exam: _____/_____/_____

MEDICAL HISTORY

Medical Conditions that you have been diagnosed with pertaining to the following:

Mental Health _____

Nervous System_____

Eyes, Ears, Nose and Throat _____

Heart and Circulation _____

Blood Pressure _____

Breathing _____

Stomach _____

Bowels _____

Urinary or Kidney_____

Sexual _____

Hormones_____

Blood _____

Chronic Pain_____

Surgeries, including year _____

_____

Injuries, including year_____

_____

_____

Medication Allergies _____

Other allergies (food, pets, insects, etc) _____

List any medical conditions of blood relatives:

Mother_____

Father_____

Other_____

SLEEP HISTORY

1. In the space below, please describe your main sleep problem(s) in your words. Include when and how this began, and what treatment you may have received in the past for this problem.

_____

_____

_____

_____

2. How often does this sleep problem occur? (Please Check One):

☐ Practically Every Night ☐ At Least Once a Week ☐ Irregularly

☐ Other: _____

3. How long has this problem been present? (Please Check One):

☐ Longer Than Two Years ☐ One Year ☐ Several Months ☐ This Month

☐ Other (Describe): _____

4. Which of the following best describes your sleep problem? (Please Check All that Apply):

☐ Difficulty Falling Asleep
☐ Wakeup During the Night for no Apparent Reason
☐ Wakeup During the Night Short of Breath
☐ Wakeup During the Night Because of Pain
☐ Wakeup During the Night to Use the Bathroom
☐ Wakeup Early in the AM
☐ Difficulty Awakening in the Morning
☐ Very Sleepy During the Day
☐ Other (Describe): _____

5. Do other members of your family have sleep problems? ☐ YES ☐ NO

If YES, please describe: _____

6. Have you ever consulted a physician in the past for your sleep problem? ☐ YES ☐ NO

If YES, please describe the Physician's Specialty: _____

7. If you answered YES to Question 6, what treatments did you receive?

_____

_____

_____

8. Please list all medications you are currently taking: You may use the CheckBox if you have already entered medication in General Medical History form

	Name	Dosage	Reason for Medication
1. ☐			
2. ☐			
3. ☐			
4. ☐			
5. ☐			

6. ☐			
7. ☐			
8. ☐			
9. ☐			
10. ☐			
	Other:		

9. Please check all the descriptions that apply to you:

☐ Tremors	☐ Take Sedatives	☐ Financial Problems
☐ Palpitations	☐ Unable to Relax	☐ Alcoholism
☐ Stomach Trouble	☐ Can't Keep a Job	☐ Memory Problems
☐ Sexual Problems	☐ Fainting Spells	☐ Panic Attacks
☐ Shy With People	☐ Nightmares	☐ Inferiority Feelings
☐ Feel Tense	☐ No Appetite	☐ Headaches
☐ Cannot Make Friends	☐ Insomnia	☐ Depressed
☐ Constipation	☐ Indigestion	☐ Reflux
☐ Dizziness	☐ Think about Suicide	☐ Cannot Make Decisions
☐ Poor Concentration	☐ Take Antacids Regularly	☐ Unable to Have a Good Time
☐ Don't Like Weekends		

☐ Others (Describe): _____

☐ Others (Describe): _____

10. Please rate the following descriptions as they occur in your situation (please **CIRCLE** one category for each question):

	Situation	Category			
A.	Wake up at night short of breath	Never	Sometimes	Frequently	Constantly
B.	Snore loudly enough that others complain	Never	Sometimes	Frequently	Constantly
C.	Suddenly wake up from sleep, gasping for breath	Never	Sometimes	Frequently	Constantly
D.	Others observe you having breathing problems during sleep	Never	Sometimes	Frequently	Constantly
E.	Observed to have leg or foot twitches during sleep	Never	Sometimes	Frequently	Constantly
F.	Experience crawling and aching feelings in your legs	Never	Sometimes	Frequently	Constantly
G.	Sleepwalking	Never	Sometimes	Frequently	Constantly
H.	Notice your heart beating strangely during the night	Never	Sometimes	Frequently	Constantly
I.	Take naps during the day	Never	Sometimes	Frequently	Constantly

J.	Fall asleep involuntarily during the day	Never	Sometimes	Frequently	Constantly
K.	Fall asleep involuntarily in the evening	Never	Sometimes	Frequently	Constantly
L.	Fall asleep while driving	Never	Sometimes	Frequently	Constantly
M.	Fall asleep during physical effort	Never	Sometimes	Frequently	Constantly
N.	Fall asleep when laughing or crying	Never	Sometimes	Frequently	Constantly
O.	Muscles become weak when extremely emotional	Never	Sometimes	Frequently	Constantly
P.	Have trouble at school due to sleepiness	Never	Sometimes	Frequently	Constantly
Q.	Have trouble at work due to sleepiness	Never	Sometimes	Frequently	Constantly
R.	Experience vivid dreams upon awakening	Never	Sometimes	Frequently	Constantly
S.	Experience vivid dreams upon falling asleep	Never	Sometimes	Frequently	Constantly
T.	Feel afraid of going to sleep	Never	Sometimes	Frequently	Constantly
U.	Have nightmares	Never	Sometimes	Frequently	Constantly
V.	Have thoughts racing through your mind	Never	Sometimes	Frequently	Constantly
W.	Feel sad and depressed	Never	Sometimes	Frequently	Constantly
X.	Have anxiety	Never	Sometimes	Frequently	Constantly
Y.	Have muscular tension	Never	Sometimes	Frequently	Constantly
Z.	Grind teeth during sleep	Never	Sometimes	Frequently	Constantly
AA.	Are bothered by pain during the day	Never	Sometimes	Frequently	Constantly
BB.	Are awakened with pain during the night	Never	Sometimes	Frequently	Constantly

11. Is your present social life satisfactory? ☐ YES ☐ NO

Does your sleep problem require you to cut back on social activity? ☐ YES ☐ NO

If YES, how? _____

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12. What is your personal interpretation as to the reason for your present sleep problem? Describe:

_____

_____

13. Please list your usual consumption of the following PER DAY (list in boxes):

☐	Coffee: _____	☐	Caffeine Colas: _____
☐	Tea: _____	☐	OTC Drugs: _____
☐	Chocolate: _____	☐	Tobacco: _____
☐	Alcohol: _____	☐	Other Drugs: _____

14. How many hours do you usually sleep per night? _____ (hours)

15. What time do you usually go to bed on: Weekdays _____ Weekends? _____

16. What time do you awaken in the morning on: Weekdays _____ Weekends? _____

17. How long does it usually take for you to fall asleep? _____

18. How many times do you typically wake up at night? _____ times

19. When you wake up at night, how long do you usually stay awake? _____

20. If you awaken during the night, after you first fall asleep, in which part of the night does it occur?

(Check all that apply): ☐ Soon after falling asleep ☐ Middle of the night ☐ Early morning

21. What do you typically do while you are awake during the night? Describe:

_____

_____

_____

22. Do you usually: (Please check all that apply)

☐ Sleep with someone else in your bed ☐ Sleep with someone else in your room

☐ Provide assistance to someone during the night (e.g., a child, an animal, etc.)

23. Is your sleep often disturbed by: (Please check all that apply)

☐ Heat ☐ Light ☐ Cold ☐ Bed Partner ☐ Noise

☐ Not being in your usual bed ☐ Other (Describe): _____

24. Do you work split shifts or rotating (variable) shifts? ☐ YES ☐ NO

25. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐ YES ☐ NO

26. Do you watch TV or read in bed before falling asleep? ☐ YES ☐ NO

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27. How do you feel after an average night of sleep?

A. ☐ Consistently good

B. ☐ Tired most of the time

C. ☐ I am Tired for: ☐ 1 Hour ☐ 2 Hours ☐ 3 Hours

28. Do you feel better during the: ☐ Morning ☐ Afternoon ☐ Evening

29. Please write down in the space below any other information the patient feels is pertinent to the sleep/wake problem that was not mentioned in the questionnaire:

_____

_____

_____

_____

_____

_____

_____

_____