Comprehensive Sleep Center

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Health History Questionnaire

Comprehensive Sleep Center

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Patient Information **Date:**

Patient SSN: **Patient Name:** (First/MI/Last)	**Sex:** M ☐ F ☐	**Date of Birth:** (mm/dd/yyyy) / /
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Referring Doctor:		**Date of Last Exam:** (mm/yyyy): _____ / _____

	Current	5 years ago
Height:		
Weight:		

Personal Health History

Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Polio ☐ Rheumatic Fever Other:

Have you been diagnosed or treated for any of the following conditions? (additional information should be placed at the bottom of the next page)
List any surgeries that you have had: (extra lines available at bottom of page)

Condition	Yes	No	Condition	Yes	No
High blood pressure	☐	☐	Pulmonary hypertension	☐	☐
Congestive Heart Failure	☐	☐	Diabetes	☐	☐
Heart disease/Heart attack	☐	☐	Lung Disease	☐	☐
Atrial fibrillation	☐	☐	Stroke	☐	☐
Arrhythmia	☐	☐	Polycythemia	☐	☐
Sleep Apnea	☐	☐	Seizures	☐	☐
Neurological disorder	☐	☐	Other:		

Surgery:	Reason:	Date:

List any other hospitalizations that you have had: (extra lines available at bottom of page)

Hospitalization:	Reason:	Date:

List all medicines that you are currently taking please include prescribed drugs, over-the-counter drugs, vitamins, inhalers, etc.: (extra lines available at bottom of page)

Name of Drug:	Strength:	Frequency Taken:	Date Started:

List each of the medications that you are allergic to, and the reaction that you had from taking the medications: (extra lines available at bottom of page)

Name of Drug:	Reaction You Had:

_____

_____

_____

_____

Health Habits and Personal Safety

Exercise:	☐ Sedentary (no exercise) ☐ Mild Exercise (climb stairs, frequent walk, golf) ☐ Occasional vigorous exercise (less than 4 times per week for 30 min.) ☐ Regular Vigorous exercise (more than 4 times per week for 30 min.)	
Diet:	Are you currently dieting?	☐ Yes ☐ No
	If yes, is it a physician-prescribed medical diet?	☐ Yes ☐ No
	Rank your salt intake.	☐ High ☐ Medium ☐ Low
	Rank your fat intake.	☐ High ☐ Medium ☐ Low
Caffeine:	☐ Any of the Following: ☐ None	☐ Cola: Cups per day ___ ☐ Tea: Cups per day ___ ☐ Coffee: Cups per day ___
Tobacco:	Do you use tobacco?	☐ Currently ☐ Previously ☐ Never
	If previously, how many years did you smoke and when did you quit?	Years_____ Date Quit _____

All information within this portion of the questionnaire is optional.

Personal Safety:	Do you live alone?	☐ Yes ☐ No
	Do you have vision or hearing deficiencies?	☐ Yes ☐ No
	Do you have an Advanced Directive and/or Living Will?	☐ Yes ☐ No
	When riding in a car, do you wear your seat belt?	☐ Yes ☐ No
Alcohol:	Do you drink alcohol?	☐ Yes ☐ No
	If yes, how many drinks per week:	_____
	Are you concerned about the amount you drink?	☐ Yes ☐ No

Family Health History

Family Member:	Problem:	Age Diagnosed:	Age at Death:

Please feel free to inform us about any other health issues here.

_____

_____

_____

_____

_____

Sleep History Questionnaire

Comprehensive Sleep Center

In your own words describe your sleep problem:

_____

_____

_____

_____

_____

1. WHAT TIME DO YOU GO TO BED? _____

2. WHAT TIME DO YOU WAKE UP? _____

3. WHAT TIME DO YOU GET OUT OF BED? _____

- *ON THE AVERAGE, HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT? _____*
- *DO YOU ALLOW YOURSELF 8HRS OF SLEEP PER NIGHT? ____NO ____YES*

4. PRIOR TO BEDTIME, DO YOU:

A. DRINK ALCOHOLIC BEVERAGES? ____NO ____YES

B. DRINK CAFFEINATED DRINKS? ____NO YES ☐ COFFEE ☐ TEA ☐ SODA

C. DO YOU TAKE SLEEPING PILLS? ____NO ____YES

IF YES, PLEASE SPECIFY FREQUENCY AND AMOUNT:

_____

Please answer by marking the appropriate box.

	NO	*YES*
DO YOU HAVE TROUBLE GOING TO SLEEP?		
DO YOU WAKE UP FREQUENTLY DURING THE NIGHT?		
DO YOU WAKE UP TOO EARLY?		
HAVE YOU EVER BEEN TOLD YOU SNORE?		
DO YOU WAKE UP GASPING OR FEELING LIKE YOU CANNOT BREATHE?		
DO YOU WAKE UP WITH A HEADACHE?		
HAS ANYONE TOLD YOU THAT YOU STOP BREATHING WHILE SLEEPING?		
DO YOU WAKE UP FEELING TIRED, DISORIENTED, OR FOGGY?		
DO YOU TOSS AND TURN AT NIGHT?		
DO YOU GET A NERVOUS/RESTLESS FEELING IN YOUR LEGS THAT IS HELPED BY WALKING OR MOVING YOUR LEGS?		
DO YOU GET LEG CRAMPS OR FEEL YOUR LEGS TINGLING?		
DO YOU DREAM SOON AFTER LYING DOWN TO SLEEP?		
DO YOU SEE THINGS OR HEAR THING THAT ARE NOT THERE BEFORE FALLING ASLEEP?		
DO YOU EVER FEEL LIKE YOU CANNOT MOVE SOON AFTER LYING DOWN TO SLEEP OR JUST AFTER YOU AWAKEN?		
DO YOU EVER FEEL WEAKNESS IN YOUR KNEES, NECK, OR ARMS WHEN LAUGHING, ANGRY, SAD, OR EMOTIONAL?		
DOES YOUR SPEECH BECOME SLURRED WHEN YOU ARE TIRED?		
DOES YOUR JAW SUDDENLY GO SLACK WHEN TELLING A JOKE SO THAT YOUR SPEECH BECOMES SLURRED?		
DID YOU EVER SLEEPWALK?		
DID YOU EVER HAVE VERY BAD NIGHTMARES?		
DID YOU EVER WAKE UP SCREAMING?		
DID YOU EVER HAVE A BED WETTING PROBLEM?		
DO YOU TALK IN YOUR SLEEP?		
DO YOU GRIND YOUR TEETH AT NIGHT?		
DO YOU SLEEP WITH MORE THAN ONE PILLOW?		
DO YOU WAKE UP TO URINATE DURING THE NIGHT?		
DO YOU FEEL EXTREMELY DROWSY DURING THE DAY?		
DO YOU FALL ASLEEP AT INAPPROPRIATE TIMES?		
DO YOU TAKE NAPS DURING THE DAY?		

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following 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

Situation	**Chance of Dozing**
Sitting and Reading	
Watching TV	
Sitting, inactive in a public place (e.g. theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Please put an **X** somewhere on the lines below:

How **Alert** do you feel?

Very Sleepy ◄----------► Very Alert

How **Good** do you feel?

Very Bad ◄----------► Very Good