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:

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

Your Past Medical History (check if you have had)

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

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
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______________________________________________________________________________________________

If you heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”? _____________________________

List any surgeries you have had:

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<th>Type of Surgery</th>
<th>How Long Ago (years)</th>
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Cigarette Smoker: Y  N  If yes: _______ pack(s)/day

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

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<tr>
<th>MEDICATION</th>
<th>HOW MUCH</th>
<th>REASON</th>
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