MEDICAL HISTORY QUESTIONNAIRE

NAME:_________________________________ **SEX:**______ **DATE:** _______________

DOB:____________________ **AGE:** _________ **PHYSICIAN:** ______________________

CHIEF COMPLAINT(S): ____
____

DAYTIME SLEEPINESS

Use this scale to choose the most appropriate number for each situation:
0 = would never doze **2 = moderate chance of dozing**
1 = slight chance of dozing **3 = high chance of dozing**

Sitting and reading ______
Watching TV ______
Sitting in a public place for example, a theatre or meeting ______
As a passenger in a car for an hour without a break ______
Lying down to rest in the afternoon ______
Sitting and talking to someone ______
Sitting quietly after lunch (when you have had no alcohol) ______
In a car, while stopped in traffic ______

CHECK ALL THAT APPLY

___ SNORING
___ WAKE UP CHOKING, SMOTHERING OR GASPING FOR AIR
___ TOLD I QUIT BREATHING DURING SLEEP
___ I HAVE BEEN AWAKENED BY MY OWN SNORING
___ I DISTURB MY PARTNER ___WE SLEEP IN DIFFERENT ROOMS
___ RESTLESS SLEEP
___ GET UP AT NIGHT TO GO TO THE BATHROOM
___ SWEATING AT NIGHT
___ HEART RACING / POUNDING / PALPITATIONS AT NIGHT
___ EXTREME FATIGUE
___ SLEEPY ALL DAY
___ MORNING HEADACHES ___DAILY ___RANDOM
___ MEMORY LOSS
___ POOR JUDGMENT OR CONCENTRATION
___ DEPRESSION ___ IRRITABILITY
___ WEIGHT CHANGE IN PAST 5 YEARS - HOW MUCH? _______
___ I HAVE FALLEN ASLEEP WHILE DRIVING
___ I CAN DRIVE FOR MILES AND NOT REMEMBER IT OR HOW I GOT SOMEWHERE
___ I HAVE FALLEN ASLEEP AT WORK
___ I HAVE BEEN LATE TO WORK BECAUSE I OVERSLEPT

How long have you had symptoms that you know of? ____________________________
Has it affected your quality of life, if so, how? ________________________________

Patient Name: ________________________________

SLEEP HABITS

What time do you typically go to bed and get up?

Weekdays: BEDTIME __________ WAKE UP _________

Weekends: BEDTIME __________ WAKE UP _________

I sleep on my: ___Back ___ Side ___Stomach ___Chair/Recliner

___I watch TV or read in bed prior to sleep
___I exercise in the evenings
___I drink caffeine in the afternoon / evening
___I drink alcohol in the evening / before bed
___I frequently watch the alarm clock
___I am a morning person –OR- ___I am a night owl

I set my thermostat at _____ degrees at night
I take naps _____ times per week
___Naps are refreshing –OR- _____Naps make me feel worse

___I cannot fall asleep
___It takes me ________hours/minutes to fall asleep
___If I wake up, it takes me ________hours/minutes to fall back asleep
___I cannot stay asleep.
___I have increased muscle tension at night
___Thoughts are racing through my mind when I try to go to sleep
___I can tell when I am not going to be able to sleep even before I go to bed
___I sometimes take sleep medicine to help me sleep
Name of medication(s):____
___I wake _____ times during the night
___I get up to use the restroom ______ times per night
___I wake up early in the morning and cannot go back to sleep
___I frequently get up during the night and watch TV or do something else
___I get up to eat at night
___I wake up feeling refreshed
___I average______hours of sleep per night
___I have dry mouth upon awakening

MOVEMENT

___I am a restless sleeper
___I kick or jerk my legs and/or arms during sleep
___I have an urge to move my legs and/or arms prior to falling asleep
___I get a sense of relief from movement
___I have restlessness, tingling or crawling sensation in my legs or arms
___I am unable to keep my legs still prior to falling to sleep
___I grind my teeth in my sleep

Patient Name: ____________________________

BEHAVIOR

___I sleepwalk
___I eat in my sleep
___I have a lot of nightmares
___I sometimes act out my dreams
___I have hurt me or my partner during sleep

OTHER

___I fall asleep unexpectedly / without warning
___When falling asleep or when waking up, I sometimes feel paralyzed (unable to move)
___I have visual hallucinations when waking up or going to sleep
___My legs, face, neck or hands get suddenly weak when I laugh or get emotional

SOCIAL HISTORY

Do you smoke? _______ How much? _______________ When did you quit? _____________
Do you drink alcohol? _______ How often? ____
Do you drink caffeine? _______ How often? ____
Do you have any history of drug use? ________
___ Single ___ Widowed
___ Married ___ Divorced
___ Employed ___ Unemployed ___ Retired Occupation:______________________
___ My job requires me to drive
___ I am a shift worker on rotating shifts
___ I am a permanent or long term night shift worker
___ I am currently a student

PAST MEDICAL HISTORY

___ High Blood Pressure
___ Heart Disease
___ Diabetes
___ High cholesterol
___ Colon problems
___ Emphysema
___ Migraines
___ Reflux or heartburn
___ Nasal allergies
___ Stroke/TIAs
___ Anemia
___ Cancer (type:________)
___ Arthritis

_____ Post Traumatic Stress Disorder
_____ Depression or anxiety
_____ Liver problems
_____ Thyroid
_____ Prostate problems
_____ Asthma
_____ Kidney Problems
_____ Seizures
_____ Neuropathy
_____ Menopause
_____ Fibromyalgia
_____ Alcohol, drug or medication addiction

Patient Name: ______________________________________

FAMILY HISTORY

Father	**Alive __**	**Deceased ___**	**Age______**	**Cause of death_______________**
Mother	**Alive __**	**Deceased ___**	**Age______**	**Cause of death_______________**
Brother(s)	**Alive __**	**Deceased ___**	**Age(s) _______**	**Cause of death_______________**
Brother(s)	**Alive __**	**Deceased ___**	**Age(s) _______**	**Cause of death_______________**
Sister(s)	**Alive___**	**Deceased ___**	**Age(s) _______**	**Cause of death_______________**
Sister(s)	**Alive___**	**Deceased ___**	**Age(s) _______**	**Cause of death_______________**

Family members with sleep problems: ____

FAMILY HISTORY (circle all that apply): hypertension – stroke – diabetes – heart disease

PAST SURGICAL HISTORY

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

WHAT DRUGS ARE YOU ALLERGIC TO? ____

CURRENT MEDICATIONS (including vitamins and supplements)

_________________________ ___________________________

_________________________ ___________________________

_________________________ ___________________________

_________________________ ___________________________

_________________________ ___________________________

_________________________ ___________________________

Patient Name: ____________________________________

IN THE PAST 12 MONTHS HAVE YOU HAD

GENERAL ___Significant illness ___Change in appetite ___Weight loss ___Stress

HEENT ___Nosebleed ___Hearing loss ___Ringing in the ears ___Trouble swallowing

CARDIO ___Chest pain ___Palpitations ___Swelling in the legs

PULM ___Cough ___Shortness or breath ___Wheezing ___Painful breathing

GI ___Heartburn ___Abdominal pain ___Diarrhea ___Constipation

GU ___Urinary urgency ___Increased frequency ___Incontinence ___Sexual dysfunction

ID ___Significant infection ___Fever ___Shaking chills

ENDO ___Extreme temperature sensitivity ___Increased thirst

DERM ___Rash ___Easy bruising

ORTHO ___Trauma ___Joint pain ___Joint swelling

NEURO ___Headache ___Focal weakness ___Trouble walking ___Loss of coordination

PSYCH ___Depression ___Mania ___Suicidal thoughts ___Panic attack

All information is true and correct to the best of my ability.

________________________________ ________________

Patient Signature **Date**

________________________________ ________________

Physician **Date**