Patient Name: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Referring doctor (MD, DO, DDS, Etc.): _____

Date of Birth: _____ Age: _____ Height: _____

Address: _____ Weight:_____

_____ Home Phone: _____

_____ Email address: _____

SYMPTOMS CHECKLIST

1. Do you snore? _____**Yes** ____**No** ____Sometimes
2. Do you stop breathing in your sleep? _____**Yes** ____**No** ____Sometimes
3. Do you awaken suddenly with a choking sensation? _____**Yes** ____**No** ____Sometimes
4. Do you awaken with headaches in the morning? _____**Yes** ____**No** ____Sometimes
5. Do you have trouble breathing though your nose? _____**Yes** ____**No** ____Sometimes
6. Do you awaken with a dry mouth? _____**Yes** ____**No** ____Sometimes
7. Do you awaken at night to urinate? _____**Yes** ____**No** ____Sometimes
8. Do you have restless legs? _____**Yes** ____**No** ____Sometimes
9. Do you feel sleepy during the day? _____**Yes** ____**No** ____Sometimes
10. Do you feel fatigued during the day? _____**Yes** ____**No** ____Sometimes
11. Do you have problems with memory or concentration? _____**Yes** ____**No** ____Sometimes

List all prescription and other medications: [PLEASE PRINT VERY CLEARLY] - use back if necessary

Name of Medication:	Reason for Medication:

Patient Name: _____ Date: _____

MEDICAL HISTORY (Check all that apply)

Do you now have or ever had:	Yes	No		***Do you now have or ever had:***	Yes	No
High Blood Pressure (HTN)				Nasal Fracture		
Chronic Obstructive Pulmonary Disease				Nasal Surgery		
Nocturnal Esophageal Reflux (GERD)				Sinus Problems		
Mood Disorders				Allergies		
Heart Problems				Asthma		
Ischemic Heart Disease				Insomnia		
History of Stroke				Tonsillectomy		
Diabetes				Swelling of Hands or Feet		

SLEEP RELATED HEALTH-CARE:

1. Have you ever had a sleep study? _____
    a. If so, when was it done? _____
    b. Who ordered it? _____
    c. Where was it done? _____
2. Are you on CPAP/BiPAP therapy? _____
    a. If so, when did you start? _____
    b. What is your pressure setting? _____
    c. Who supplied your machine? _____
3. Are you on home oxygen? _____
    a. If so, when did you start? _____
    b. What company supplies your oxygen? _____

List all major surgeries: [PLEASE PRINT VERY CLEARLY] – use back if necessary

Type of Surgery:	**Year of Surgery:**

Please describe the sleep-related issue that brings you to the sleep center:

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ Date: _____

EPWORTH SLEEPINESS SCALE

Please rate the chance of you dozing in the following situations:

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 *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	_____
Add the numbers for a total:	_____

SOCIAL HISTORY

Have you ever smoked? _____**Yes** _____**No**
If yes, for how many years? _____
Average number of packs per day? _____
Have you quit smoking? _____**Yes** _____**No**
How long ago? _____

Do you drink caffeinated beverages? _____**Yes** _____**No**
If yes, how much per day? _____

Do you drink alcoholic beverages? _____**Yes** _____**No**
If yes, how much and how often? _____

Do you get regular exercise? _____**Yes** _____**No**
If yes, how often? _____

SLEEP SCHEDULE

Normal Bedtime: Weeknights: _____ Weekends_____
Normal Wake up time: Weekdays: _____ Weekends_____

Additional Notes: