National Sleep Solutions Inc.

Sleep Specialist

SLEEP QUESTIONNAIRE
AND
MEDICAL HISTORY

Name: ____ Social Security Number: ________________

Date of Birth:___________ Age: ____ Height: ____ Weight: ________ □ Male □ Female

Primary MD: _______________________________ Referring MD: ___________________________

Legally Authorized Representative (if applicable): ____

Language and Communication Needs:____

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

Chief Complaint(s)

□ Difficulty falling asleep □ Difficulty staying asleep □ Fatigue despite adequate sleep □ Snoring

□ Significant daytime drowsiness □ Witnessed apnea □ Gasping / choking upon awakening

□ Sleep walking / talking □ Night terrors □ Acting out dreams □ Legs kick / move while sleeping

□ Morning headaches □ Insomnia □ Other: ______________________________________

History of Present Illness

1. How long have you had this problem? □ < 1 month □ 1-6 months □ 6 months-2 years □ >2 years
2. Rate the severity of your problem. □ Mild □ Moderate □ Severe □ Problem only for others
3. Is your sleep-related problem getting worse? □ Yes □ No
4. What factors aggravate your symptoms? ____
5. Does your problem have a negative impact on your
   - ………. work performance □ Yes □ No
   - ………. sex life □ Yes □ No
   - ………. quality of life □ Yes □ No
   - ………. social activities □ Yes □ No
6. Do you use any medications or other substances to help you sleep? □ Yes □ No
   If yes, please list drug / substance(s), dose, frequency, and length of usage.
   ____
7. Do any members of your family have significant sleep-related problems? □ Yes □ No
   If yes, please explain:
   ____
8. Have you discussed your sleep-related problems with another doctor? □ Yes □ No
   Doctor's Name: ____________________________________ Diagnosis: __________________
   Treatment: ____

Please rate how often you or others note that you:

	Never	Occasionally	Frequently
Snore	_____	_____	_____
Snore loudly enough for others to complain	_____	_____	_____
Awaken from sleep feeling short of breath, gasping, or choking	_____	_____	_____
Hold your breath or stop breathing while asleep	_____	_____	_____
Experience other breathing problems at night	_____	_____	_____
Wake up with a headache that improves in less than 2 hours	_____	_____	_____
Have dry mouth upon awakening	_____	_____	_____
Sweat excessively at night	_____	_____	_____
Experience heart pounding or irregular heart beats during night	_____	_____	_____
Feel sleepy or tired during the day	_____	_____	_____
Awaken feeling unrested or unrefreshed	_____	_____	_____
Become drowsy while driving	_____	_____	____
Have motor vehicle accidents due to sleepiness	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____
Become irritable or crabby	_____	_____	_____
Have difficulty concentrating; experience memory impairment	_____	_____	_____
Fall asleep involuntarily, suddenly or in an awkward situation	_____	_____	_____
Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations	_____	_____	_____
Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness	_____	_____	_____
Have nightmares or night terrors	_____	_____	_____
Act out dreams by yelling and swinging arms and legs	_____	_____	_____
Walk or talk while asleep	_____	_____	_____
Do anything else considered “unusual” while asleep	_____	_____	_____
Move, twitch or jerk your legs while asleep	_____	_____	_____
Feel leg restlessness, agitation or discomfort at or before bedtime	_____	_____	_____
If yes: Do you feel an overwhelming urge to move your legs?		□ Yes	□ No
Does it happen only in the evening?		□ Yes	□ No
Does it only happen when you are relaxed?		□ Yes	□ No
Does it get better if you move around or walk?		□ Yes	□ No
Does it disturb your sleep or sleep onset?		□ Yes	□ No

How often do you experience this feeling? ____

Patient’s Initials: _______

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Sleep Hygiene

1. Do you often have anxiety around bedtime? □ Yes □ No
2. Do you have thoughts racing through your mind while trying to fall asleep? □ Yes □ No
3. Do you sleep better away from home than in your own bed? □ Yes □ No
4. Are you anxious or upset if you have difficulty falling asleep? □ Yes □ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? □ Yes □ No
6. Do you exercise within 2 hours of your bedtime? □ Yes □ No
7. Do you watch TV or read in bed before falling asleep? □ Yes □ No
8. Do you ever nap or rest during the awake portion of your day? □ Yes □ No

   If yes: How often? ___________ times per day; ___________ times per week

   How long is your nap / rest? □ < one hour □ ≥ one hour

   After the nap / rest, do you still feel tired? □ Yes □ No

9. Check conditions that routinely apply to you: □ Sleep alone □ Sleep with someone else in bed □ Sleep with pet in room/bed □ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: □ Heat □ Cold □ Light □ Noise □ Bed Partner Other: ______________________________

Sleep Habits

1. When do you feel your very best? □ Morning □ Afternoon □ Evening
2. Approximately, how many hours do you actually sleep per night? ____________________________
3. What time do you usually go to bed? Workdays: ____________ Non-Workdays: ____________
4. What time do you usually rise from bed? Workdays: __________ Non-Workdays: __________
5. How long does it usually take for you to fall asleep? ______________________________________
6. How many hours of sleep do you need to feel your very best? _______________________________
7. In an perfect world, what would be the ideal hour for you to go to bed? ________________________
8. In an perfect world, what would be the ideal hour for you to awaken? _________________________
9. What usually prevents you from quickly falling asleep? _____________________________________
10. How many times do you typically wake up during the night? ________________________________
11. What generally causes you to wake up during the night? ___________________________________
12. If you wake up during the night, how long do you typically stay awake? _______________________
13. If you wake up during the night, when do you typically wake up?

    □ Soon after falling asleep □ In the middle of the night □ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _________________________________

Patient's Initials: _______

MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

- ☐ Angina
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Arteriosclerosis
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ Stroke
- ☐ Peripheral artery disease
- ☐ Other cardiovascular disorders ___________

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Other respiratory disorders ___________

- ☐ Acid reflux
- ☐ Diverticulitis
- ☐ Hiatal hernia
- ☐ Swallowing disorder
- ☐ Stomach ulcers
- ☐ Other gastrointestinal disorders __________

- ☐ Arthritis
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Autoimmune disorder
- ☐ Neuromuscular disorder

- ☐ Diabetes
- ☐ Sickle cell anemia
- ☐ Thyroid disease
- ☐ Cancer

- ☐ Migraines
- ☐ Seizures / Epilepsy
- ☐ Brain infection
- ☐ Brain injury
- ☐ Spinal infection
- ☐ Spinal injury
- ☐ Nerve injury
- ☐ Other neurologic disorders ______________________

- ☐ Liver disease
- ☐ Kidney disease
- ☐ Blood disorder

- ☐ Depression
- ☐ Anxiety / Panic attacks
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Other psychiatric disorders ______________________

Current Medications: Please list all medications that you are currently taking and their dosages:

____

____

Drug Allergies: Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list:

____

Past Surgeries: Please list all operations and the approximate date of the procedure. __________________

____

Family History: Has anyone in your blood-related family been afflicted with the following conditions:

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer

☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs syndrome ☐ Sleep walking / talking ☐ Parasomnias

Occupational History: Occupation: __________________ Are you a shift worker? ☐ Yes ☐ No

If yes, please describe work schedule: ____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children living at home: ☐ No ☐ Yes Ages of children: ______________________________

Others living at home: ☐ No ☐ Yes ☐ Spouse ☐ Parents / Grandparents ☐ Friend

Alcohol consumption: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic

Tobacco use ☐ No ☐ Yes If yes, Type: ___________ Frequency: ____________

Recreational drug use ☐ No ☐ Yes If yes, Type: ___________ Frequency: ____________

Patient's Initials: _______

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REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

General
- □ Fatigue
- □ Malaise / lethargy
- □ Generalized weakness
- □ Loss of appetite
- □ Weight loss
- □ Weight gain
- □ Night sweats
- □ Fever / chills

Eyes
- □ Vision changes
- □ Double vision
- □ Discharge
- □ Pain
- □ Sensitivity to light

Ears, Nose, Throat and Mouth
- □ Earache
- □ Ringing in the ears
- □ Allergies
- □ Frequent colds
- □ Nasal congestion
- □ Nosebleeds
- □ Sinusitis
- □ Toothache
- □ Oral ulcers
- □ Dry mouth
- □ Facial pain
- □ Jaw pain
- □ Hoarse voice
- □ Sore throat
- □ Difficulty swallowing
- □ Swollen glands

Cardiovascular System
- □ Chest pain
- □ Pain in arm, shoulder, jaw, neck or back
- □ Rapid heart rate
- □ Irregular heartbeat
- □ Dizziness
- □ Pain in leg when walking
- □ Ankle / leg swelling

Lungs
- □ Chronic cough
- □ Shortness of breath with mild exertion
- □ Difficulty breathing
- □ Wheezing
- □ Bloody sputum

Gastrointestinal System
- □ Nausea / vomiting
- □ Indigestion
- □ Acid reflux
- □ Diarrhea
- □ Constipation
- □ Cramps
- □ Bloating
- □ Vomiting blood
- □ Blood in stool
- □ Abdominal pain
- □ Abdominal swelling
- □ Rectal pain
- □ Rectal bleeding

Genitourinary System
- □ Frequent urination
- □ Painful urination
- □ Urinary incontinence
- □ Blood in urine
- □ Pelvic / groin pain
- □ Genital ulcers

Male:
- □ Erectile dysfunction
- □ Testicular pain / swelling

Female:
- □ Irregular periods
- □ Hot flashes
- □ Vaginal discharge

Musculoskeletal System
- □ Joint pain / swelling
- □ Back pain
- □ Muscle pain / weakness
- □ Leg cramps

Nervous System
- □ Headaches / migraines
- □ Dizziness / fainting
- □ Seizures
- □ Tremors
- □ Disorientation
- □ Lack of coordination
- □ Numbness / paralysis
- □ Memory loss / impairment

Psychiatric Symptoms
- □ Depression
- □ Anxiety / panic attacks
- □ Hallucinations
- □ Delirium
- □ Dementia
- □ Suicidal ideation

Endocrine System
- □ Heat intolerance
- □ Cold intolerance
- □ Excessive thirst
- □ Sexual dysfunction
- □ Hair loss
- □ Excessive sweating

Skin
- □ Rashes
- □ Bruises
- □ Hives
- □ Lesions

Patient's Signature ______________________________________ Date ___________________