Patient History Questionnaire

Patient Name Date

1. What is your current height _____ weight _____ Neck or collar size: _____?

2. What is your bedtime on WEEKDAYS? _____ WEEKENDS? _____

   What time you get up on WEEKDAYS? _____ WEEKENDS? _____

3. Do you take naps? _____Yes _____No
   If yes, do you feel rested and refreshed? _____Yes _____No

4. Do you consume caffeine? _____ No _____ Yes
   If yes, please describe how much and how often. _____

5. Do you smoke? _____Yes _____No If yes, how many packs per day: _____

6. What percentage of the night do you sleep in following positions? _____Back _____Sides _____Stomach

7. How would you rate your current general health? ____ very poor ____ poor ____ average ____ good ____ very good

8. Have you ever had a sleep study? _____Yes _____No
   If yes, when and where? _____

9. Are you currently on CPAP therapy? _____Yes _____No If yes, what pressure are you presently using? _____

10. What is your occupation? _____

11. Check if you now have or in the past had the following? (√ o Now o Past)

Diabetes (Type I or Type II)	o Now	o Past	Temporomandibular Joint Dysfunction (TMJ)	o Now	o Past
High Blood Pressure	o Now	o Past	Anemia	o Now	o Past
Stroke / TIA	o Now	o Past	Peptic Ulcers	o Now	o Past
Heart Disease or CHF	o Now	o Past	Acid Reflux (Heartburn)	o Now	o Past
Heart Attack	o Now	o Past	Kidney Disease	o Now	o Past
Angina	o Now	o Past	Thyroid Disease	o Now	o Past
Emphysema or COPD	o Now	o Past	Arthritis	o Now	o Past
Asthma	o Now	o Past	Back Pain	o Now	o Past
Tuberculosis	o Now	o Past	Head Trauma	o Now	o Past
Other Lung Disease	o Now	o Past	Severe Headaches	o Now	o Past
Nasal Allergies	o Now	o Past	Epilepsy or Seizures	o Now	o Past
Runny or Blocked Nose	o Now	o Past	Passing out Spells (Fainting)	o Now	o Past
Hormonal Problem	o Now	o Past	Depression	o Now	o Past
Urological Problem	o Now	o Past	Anxiety Disorder	o Now	o Past
Prostate Disease	o Now	o Past	Problems with Drugs and/or Alcohol	o Now	o Past

12. If you have any other medical condition(s) not listed above, please list it below:

_____

_____

13. Do you have a family history of any major diseases or sleep disorders? If yes, please describe:

_____

_____

14. <u>Check the box for each problem you CURRENTLY have:</u>

- ☐ Loud snoring
- ☐ Witnessed Apnea
- ☐ Frequent awakenings
- ☐ Choking for breath at night
- ☐ Gasping during sleep
- ☐ Restless sleep
- ☐ Morning headaches
- ☐ Awaken un-refreshed
- ☐ Crawling feelings in legs when trying to sleep
- ☐ Leg-kicking during sleep
- ☐ Leg cramps in sleep
- ☐ Trouble falling asleep or staying asleep at night
- ☐ Racing thoughts when trying to sleep
- ☐ Increased muscle tension when trying to sleep
- ☐ Fear of being unable to sleep
- ☐ Inability to fall back asleep after awakening at night
- ☐ Lying in bed worrying when trying to sleep
- ☐ Waking too early in the morning
- ☐ Night Sweats
- ☐ Waking up with heartburn or reflux
- ☐ Morning dry mouth
- ☐ Teeth grinding during sleep
- ☐ Tongue biting in sleep
- ☐ Acting out dreams
- ☐ Sleep terrors
- ☐ Nightmares
- ☐ Sleepwalking
- ☐ Sleep talking
- ☐ Waking up to urinate
- ☐ Bedwetting
- ☐ Feeling paralyzed when falling asleep or waking up
- ☐ Dreamlike images when falling asleep or waking up
- ☐ Sudden weakness when laughing or afraid
- ☐ Uncontrollable daytime sleep attacks
- ☐ Falling asleep unexpectedly
- ☐ Falling asleep at work or school
- ☐ Falling asleep while driving
- ☐ Recent change in sleep schedule
- ☐ Shift work interfering with sleep
- ☐ Use of sleeping pills to help with sleep
- ☐ Use alcohol to help sleep
- ☐ Pain interfering with sleep

15. MEDICATIONS – please list all medications you are currently taking. This includes prescription drugs, non-prescription drugs, vitamins, and herbal substances.

Drug, Vitamin, or Herbal Substance	Dose	Reason for taking?	Currently taking? Yes / No

EPWORTH SLEEPINESS SCALE: *Please give the answer that most accurately describes the chances of you dozing off or falling asleep in the following situations. This refers to your usual way of life in recent times. IF YOU ARE ALREADY ON CPAP or BIPAP, PLEASE ANSWER THESE QUESTIONS INDICATING THE WAY YOU FEEL WHEN YOU ARE USING CPAP or BIPAP.*

CHANCE OF DOZING OFF:

Never	Slight	Medium	High	
0	1	2	3	Sitting and reading
0	1	2	3	Watching TV
0	1	2	3	Sitting, inactive in a public place (such as, a theater or meeting)
0	1	2	3	As a passenger in a car for an hour without a break
0	1	2	3	Lying down to rest in the afternoon when circumstances permit
0	1	2	3	Sitting and talking to someone
0	1	2	3	Sitting quietly after lunch without having consumed alcohol
0	1	2	3	In a car, while stopped for a few minutes in traffic

Total score: _____