

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____

Height: _____ Weight: _____ Neck or collar size: _____



1. What is your bedtime on WEEKDAYS? _____ WEEKENDS? _____
What time do 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? ____ Yes ____ No If yes, what 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 any type of PAP therapy (CPAP, BIPAP, APAP, ASV, AVAPS)? ____ Yes ____ No
If yes, what pressure are you presently using? _____ What style of mask are you using? _____
10. What is your occupation? _____
11. Check if you now have or in the past had the following? ☒ (☐ Now ☐ Past)

Diabetes (Type I or Type II)	<input type="checkbox"/> Now <input type="checkbox"/> Past	Temporomandibular Joint Dysfunction (TMJ)	<input type="checkbox"/> Now <input type="checkbox"/> Past
High Blood Pressure	<input type="checkbox"/> Now <input type="checkbox"/> Past	Anemia	<input type="checkbox"/> Now <input type="checkbox"/> Past
Stroke / TIA	<input type="checkbox"/> Now <input type="checkbox"/> Past	Peptic Ulcers	<input type="checkbox"/> Now <input type="checkbox"/> Past
Heart Disease or CHF	<input type="checkbox"/> Now <input type="checkbox"/> Past	Acid Reflux (Heartburn)	<input type="checkbox"/> Now <input type="checkbox"/> Past
Heart Attack	<input type="checkbox"/> Now <input type="checkbox"/> Past	Kidney Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past
Angina	<input type="checkbox"/> Now <input type="checkbox"/> Past	Thyroid Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past
Emphysema or COPD	<input type="checkbox"/> Now <input type="checkbox"/> Past	Arthritis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Asthma	<input type="checkbox"/> Now <input type="checkbox"/> Past	Back Pain	<input type="checkbox"/> Now <input type="checkbox"/> Past
Tuberculosis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Head Trauma	<input type="checkbox"/> Now <input type="checkbox"/> Past
Other Lung Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past	Severe Headaches	<input type="checkbox"/> Now <input type="checkbox"/> Past
Nasal Allergies	<input type="checkbox"/> Now <input type="checkbox"/> Past	Epilepsy or Seizures	<input type="checkbox"/> Now <input type="checkbox"/> Past
Runny or Blocked Nose	<input type="checkbox"/> Now <input type="checkbox"/> Past	Passing out Spells (Fainting)	<input type="checkbox"/> Now <input type="checkbox"/> Past
Hormonal Problem	<input type="checkbox"/> Now <input type="checkbox"/> Past	Depression	<input type="checkbox"/> Now <input type="checkbox"/> Past
Urological Problem	<input type="checkbox"/> Now <input type="checkbox"/> Past	Anxiety Disorder	<input type="checkbox"/> Now <input type="checkbox"/> Past
Prostate Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past	Problems with Drugs or Alcohol	<input type="checkbox"/> Now <input type="checkbox"/> 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. Check the box for each symptom / problem you CURRENTLY have:

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

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

Drug, Vitamin, or Herbal Substance	Dose	Taken for how long?	Reason for taking?

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:

<u>Never</u>	<u>Slight</u>	<u>Medium</u>	<u>High</u>	
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: _____