

History Questionnaire

Name _____ Date _____

Referring Physician _____

SS# _____ DOB _____ Age _____ Sex M F

Height _____ Weight _____ Occupation _____

Emergency Contact/Phone: _____

The following questions will help us understand more about you. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Please do not leave any questions unanswered. Please feel free to use the back of this page, if more space is needed.

1.) Briefly describe the nature of your chief complaint: _____

2.) Signs & Symptoms (*place a check by ALL of the following Signs and Symptoms which apply to you*):

- | | | |
|--|--|--|
| <input type="checkbox"/> Heavy Snoring | <input type="checkbox"/> Snoring interrupted by silence and then gasping | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Grinding of the teeth | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Awakens with sour/bitter taste in the mouth | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Short Temper | <input type="checkbox"/> Falling asleep at inappropriate times | <input type="checkbox"/> Fatigue/Malaise |
| <input type="checkbox"/> Lack of Energy | <input type="checkbox"/> Falling asleep unintentionally | <input type="checkbox"/> Loss of Libido |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Drowsiness |

3.) About how long have you had this problem? _____ Months _____ Year

4.) About how long has this problem affected your life? _____ Months _____ Year

Medical History (*please check all that apply*):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Nose Fracture |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Hiatal Hernia/Reflux | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> COPD (emphysema, etc.) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sleep Disorder: _____ | | <input type="checkbox"/> Smoking: # of years: _____ Packs/day _____ | |
| <input type="checkbox"/> Medication allergies _____ | | Have you quit? Y N When? _____ | |

5.) Briefly describe any serious illnesses or major medical procedures you have experienced and the date they were incurred:

6.) List medications your are currently taking:

For the following questions, please circle the response that best describes you:

- | | | | | | |
|---|-------|-----------|-------|------------|--------|
| 7. Have you been told that it appears your breathing 'stops' during your sleep? | Never | Sometimes | Often | Frequently | Always |
| 8. Do you 'toss' & 'turn' frequently when sleeping? | Never | Sometimes | Often | Frequently | Always |
| 9. Do you have difficulty falling asleep? | Never | Sometimes | Often | Frequently | Always |
| 10. Is it difficult for you to 'stay' asleep? | Never | Sometimes | Often | Frequently | Always |
| 11. Do you kick your legs or jerk during your sleep | Never | Sometimes | Often | Frequently | Always |
| 12. Do you experience a creeping sensation in your legs and feet at night as though you must move them? | Never | Sometimes | Often | Frequently | Always |
| 13. Are there times where you feel as if you must fall asleep and cannot stop it from happening (sleep attack)? | Never | Sometimes | Often | Frequently | Always |
| 14. Do you feel muscle weakness or have you collapsed from feeling strong emotions (laughter, scared, etc.)? | Never | Sometimes | Often | Frequently | Always |
| 15. Do you sometimes feel unable to move when waking up or falling asleep (paralyzed feeling)? | Never | Sometimes | Often | Frequently | Always |
| 16. Do you experience vivid, dream-like imagery when falling asleep or waking up? | Never | Sometimes | Often | Frequently | Always |
| 17. Do naps make you feel refreshed? | Never | Sometimes | Often | Frequently | Always |
| 18. Do you require special conditions to fall asleep at night? | Never | Sometimes | Often | Frequently | Always |

If yes, please describe:

- | | | | | | |
|---|-------|-----------|-------|------------|--------|
| 19. Do you drink alcohol before going to bed or during the night? | Never | Sometimes | Often | Frequently | Always |
| 20. When trying to sleep, do you have anxious thoughts or racing thoughts in your mind? | Never | Sometimes | Often | Frequently | Always |
| 21. Do you awaken with anxiousness, worry or panic? | Never | Sometimes | Often | Frequently | Always |
| 22. Is your sleep disturbed by a medical condition? | Never | Sometimes | Often | Frequently | Always |

If yes, please describe:

- | | | | | | |
|--|-------|-----------|-------|------------|--------|
| 23. Do you awaken because of aches or pains? | Never | Sometimes | Often | Frequently | Always |
| 24. Do you have trouble going back to sleep if you wake up during the night? | Never | Sometimes | Often | Frequently | Always |
| 25. Are you bothered by outside noises during the night, such as planes, trains or barking dogs? | Never | Sometimes | Often | Frequently | Always |
| 26. As bedtime approaches, do you become anxious? | Never | Sometimes | Often | Frequently | Always |
| 27. When you awaken at night, do you lie there until you fall back asleep? | Never | Sometimes | Often | Frequently | Always |