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Medical History Form

Patient Name: ______________________________ (Last, First Initial) Date: ______________________________

Age: _____ Height: ____ Weight: _____ Marital Status: ______ Referring Physician _______________________

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Why Are You Here? (Reason for the study in your own words): ____

____

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Sleep Schedule

1. What time on weekdays do you usually — Go to bed ?__________ Wake up? _________
   What are your usual working hours if applicable — Begin? _____________ End? _____________
2. What time on weekends do you usually — Go to bed? __________ Wake up? _________
3. On average, how long do you actually sleep at night? — Weekdays?__________ Weekends? _________
4. Do you feel that you get too much or too little sleep at night — Too much? _________ Too little? __________

Night Time Symptoms

5. How long does it normally take you to fall asleep at night? — Minutes _____
6. Do you have thoughts that prevent sleep? — Yes ________ No _______
7. Do you have trouble getting to sleep at night? — Yes ________ No _______
8. Do you awaken at night to use the bathroom? — Yes ________ No _______ How often? _________
9. Are you ever awakened by a "coughing spell" during the night? — Yes ________ No _______
10. Do you have crawling sensations in your legs while falling asleep? Yes ________ No _______
11. Do you have twitching movements in your legs during the night? — Yes ________ No _______
12. Do you awaken with racing thoughts, sadness or anxiety? — Yes ________ No _______
13. Have other people told you that you have restless sleep? — Yes ________ No _______
14. Do you have difficulty going back to sleep during the night? — Yes ________ No _______
15. Does anyone tell you that you snore badly? — Yes ________ No _______
16. Do you have difficulty breathing at night? — Yes ________ No _______
17. Do you wake up with headaches? — Yes ________ No _______ How often? _________
18. Do you awaken with a sour or bitter taste in your mouth? — Yes ________ No _______ How often? _________
19. Is it difficult for you to awaken and get out of bed after sleeping? — Yes ________ No _______ How often? _________
20. Have you experienced paralysis while falling asleep or waking up? Yes _______ No _______ How often? _________
21. Do you have vivid dreams as you are falling asleep? — Yes ________ No _______ How often? _________
22. Is your sleep disturbed by a medical problem (Y/N)? _______; Describe: ____________________________________

Day Time Symptoms

23. Do you deliberately take naps during the day Yes ____ No _______ How often? _______ How Long __________
24. Do you feel rested or refreshed after a nap? Yes ________No _______
25. Are you bothered by sleepiness during the day? Yes ________No _______ How often? _________
26. Do you find yourself falling asleep when you don't mean to? Yes ________No _______ How Long __________
27. Do you take naps during the day? No Need _______ I want to but can't _______Number of times a week __________
28. Do you fall asleep during these situations?

0 = no chance of dozing, **1** = slight chance of dozing, **2** = moderate chance of dozing, **3** = high chance of dozing

- *Sitting and reading* 0 1 2 3
- *Watching TV* 0 1 2 3
- *Sitting inactive in a public place?* 0 1 2 3
- *As a passenger in a car for an hour with out 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 a lunch without alcohol* 0 1 2 3
- *In a car, while stopped for a few minutes in traffic* 0 1 2 3

_______ **Total**

29. Have you noticed, or been told about, any changes in your personality recently, such as:
    a) irritability Yes______ No______
    b) increased temper Yes______ No______
    c) anxiety Yes______ No______
    d) depression Yes______ No______
    e) loss of concentration Yes ______No ______
    f) "spaced out" feeling Yes ______No ______
    g) decreased job productivity Yes ______No ______
    h) poor memory Yes ______No ______
30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation (for example, when laughing, if angry, if in an exciting situation, etc.)? (Check one on each line):

	Never	1-5 times in your life	Monthly	Weekly	Daily - almost daily
Knees buckling					
Mouth opening					
Head nodding					
Falling down					

Do you know, or others tell you that you:	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grind teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

Health History

- □ Weight Problems
- □ High blood pressure
- □ Shortness of breath
- □ Deviated nasal septum
- □ Sinus Problems
- □ Tonsillectomy
- □ Sinus Surgery
- □ Chronic Cough
- □ Chronic Bronchitis
- □ Asthma
- □ Emphysema
- □ Lung Disease
- □ Ulcers
- □ Colitis
- □ Kidney problems
- □ Thyroid Disorder
- □ Diabetes
- □ Heart Disease
- □ Neurologic Disease
- □ Anxiety
- □ Dementia
- □ Depression
- □ Psychiatric
- □ Stroke
- □ Cancer
- □ Narcolepsy
- □ Chronic Fatigue
- □ Fibromyalgia
- □ Parkinson's

31. Please list any other health or surgical history ____
____
____
____
____

If anyone in your family had sleep problems, please list the problem & your relationship____________________
____
____
____

Medications: ***Please list below or attach to the back of this questionnaire***

Medications	Amount	How Often	Years	Reason	Medications	Amount	How Often	Years	Reason

32. For each of the beverages listed below, please write the average amount you drink daily:
    Regular coffee(Cups)_____
    Hot or Iced tea (Cups) _____
    Caffeinated soft drinks _____
33. Do you smoke cigarettes (Y/N)? _____ If YES, how many packs per day? _____ For how many years? ______
    If NO, did you ever smoke (Y/N)? _______ When did you stop smoking? _______
34. How many alcoholic beverages do you drink per day on weekdays ______ / weekends? ______ or per month ______
35. If there are any other aspects that you feel are important, please describe them here or on the back of this page.

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____
____
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