

PATIENT HISTORY

Date: _____ Two forms Identification: _____

Name: _____
(first) (middle) (last)

Address: _____
(street) (City) (state) (zip)

Date of Birth: _____ Age: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____

Height: _____ Weight: _____ Neck Size: _____

Married: _____ Separated: _____ Divorced: _____ Single: _____

Spouse's Name: _____

Your Education: _____ Your Occupation: _____

Place of Employment: _____

In case of an Emergency contact: _____
(name) (phone) (relationship)

Referring Physician: _____ Phone: _____

Physician's Address: _____

Insurance : _____

How did you hear about our sleep center?

_____ Physician

_____ Magazine journal

_____ Relative

_____ Television

_____ Friend

_____ Radio

_____ Newspaper

_____ Seminar

_____ Sleep Society

_____ Other _____

The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete this questionnaire as thoroughly as you can.

This information will be held in the strictest confidence.

1. How many hours of sleep do you get per night? _____

2. What time do you usually go to bed on WEEKDAYS? _____

3. How long does it take for you to fall asleep? _____
4. How many times do you typically wake up at night? _____
5. If you wake up, how long do you stay awake? _____
6. If you do awaken during the night, which part(s) of your sleep period is it?
☐ soon after falling asleep
☐ middle of the night
☐ early part of the morning
7. What do you usually do when you awaken during the night? _____

8. What time do you usually awaken in the mornings on WEEKDAYS? _____
WEEKENDS? _____
9. On the average, how long do you stay in bed after waking up in the mornings?

10. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

11. Has it been a continuous or intermittent problem?
☐ almost every night
☐ for periods of at least one week
☐ irregularly
☐ other _____
12. How long has this problem bothered you?
☐ longer than 2 years
☐ 1 – 2 years
☐ several months
☐ within the past 3 months
☐ within the past month

13. On the scale below, please estimate the severity of your problem(s).

_____ mildly upsetting	_____ moderately severe
_____ very severe	_____ extremely severe
_____ totally incapacitating	

14. How do you describe your sleep problem? (check all that apply to you)

- ☐ difficulty falling asleep
- ☐ wake up during the night
- ☐ wake up early in the morning
- ☐ excessive daytime sleepiness
- ☐ difficulty awakening

15. Do any other members of your family been diagnosed with a sleep problem? Please explain. _____

16. Do you usually: (check all that apply to you)

- ☐ sleep with someone else in your bed
- ☐ sleep with someone else in your room
- ☐ provide assistance to someone during the night (child, invalid, animal)

17. Is your sleep often disturbed by:

- ☐ heat
- ☐ cold
- ☐ noise
- ☐ light
- ☐ bed partner
- ☐ other _____

18. Are your sleep habits on weekends different from the rest of the week?

- ☐ No
- ☐ Yes – please describe _____

19. Do you work split shifts or variable shifts and is your job satisfactory? _____

20. Do you usually drink coffee or tea within 2 hours before you go to bed?

- ☐ yes
- ☐ no

21. Do you do physical exercise before bedtime? ☐ yes ☐ no

22. Do you read before falling asleep? ☐ yes ☐ no

23. Do you take naps during the afternoon or evening?

- ☐ never
☐ seldom
☐ frequently – if so, for how long? _____

24. Do you feel refreshed after a short (10 – 15 minute) nap? ☐ yes ☐ no

25. How do you feel after an average night of sleep?

- ☐ usually drowsy and/or tired – if so, for how long?
☐ 1 hour
☐ 2 hours
☐ 3 hours
☐ longer
☐ most of the time good
☐ consistently good

26. Do you feel better during: ☐ morning ☐ afternoon ☐ evening

27. List your consumption of the following per day:

Coffee _____	Chocolate _____
Tea _____	Nicotine _____
Colas _____	Drugs _____
Alcohol _____	Over the counter _____

28. Please underline any of the following that apply to you:

Headaches	Dizziness
Palpitations	Stomach trouble
Bowel disturbances	Fatigue
Nightmares	Take sedatives
Feel tense	Suicidal ideas
Depressed	Feel panicky
Unable to relax	Sexual problems
Financial problems	Overambitious
No appetite	Inferiority problems
Alcoholism	Memory problems
Take drugs	Don't like weekends or vacations
Can't make decisions	Can't make friends
Tremors	Can't keep a job
Home conditions bad	Unable to have a good time
Fainting spells	Concentration difficulties
Insomnia	Take antacids regularly
Shy with people	(Tums, Tagamet, Pepcid, etc.)

29. Please check the appropriate answer for the following statements.

How often do you:	Never	Rarely	Sometimes	Frequently	Constant
Awaken from sleep short of breath?	_____	_____	_____	_____	_____
Are told that you snore loudly?	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching or coughing?	_____	_____	_____	_____	_____
Wake up with a headache in the morning?	_____	_____	_____	_____	_____
Have trouble sleeping when you have a cold?	_____	_____	_____	_____	_____
Fall asleep at public gatherings (movies,church)?	_____	_____	_____	_____	_____
Have breathing problems at night/	_____	_____	_____	_____	_____
Sweat excessively at night?	_____	_____	_____	_____	_____
Are bothered by long periods of wakefulness during the night?	_____	_____	_____	_____	_____
Notice your heart pounding or beating irregularly at night?	_____	_____	_____	_____	_____
Feel refreshed after a short nap?	_____	_____	_____	_____	_____
Fall asleep during the day?	_____	_____	_____	_____	_____
Fall asleep involuntarily?	_____	_____	_____	_____	_____
Fall asleep while reading the newspaper?	_____	_____	_____	_____	_____
Fall asleep while driving?	_____	_____	_____	_____	_____
Are you bothered by waking up too early and not being able to get back asleep?	_____	_____	_____	_____	_____
Fall asleep during physical effort?	_____	_____	_____	_____	_____
Fall asleep while watching TV?	_____	_____	_____	_____	_____
Fall asleep when laughing or crying?	_____	_____	_____	_____	_____
Fall asleep while talking to people?	_____	_____	_____	_____	_____
Fell weak as though you might fall when you are emotional (laughing,crying,or angry)?	_____	_____	_____	_____	_____
Have difficulty with sexual functioning?	_____	_____	_____	_____	_____
Have trouble at school or work because of sleepiness?	_____	_____	_____	_____	_____
Fallen asleep while on the job?	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep?	_____	_____	_____	_____	_____
Feel confused when awakening from sleep?	_____	_____	_____	_____	_____
Experience vivid dreams upon awakening or falling asleep?	_____	_____	_____	_____	_____

Dream during daytime hours?	_____	_____	_____	_____	_____
Feel afraid of going asleep?	_____	_____	_____	_____	_____
Have nightmares?	_____	_____	_____	_____	_____
Talk during sleep?	_____	_____	_____	_____	_____
Remember your dreams?	_____	_____	_____	_____	_____
Sleep walk – now or in the past?	_____	_____	_____	_____	_____
Have thoughts racing through your mind?	_____	_____	_____	_____	_____
Feel sad or depressed?	_____	_____	_____	_____	_____
Have anxiety (worry about things)?	_____	_____	_____	_____	_____
Have muscular tension?	_____	_____	_____	_____	_____
Notice parts of your body jerk?	_____	_____	_____	_____	_____
Strike out or make violent movements during sleep?	_____	_____	_____	_____	_____
Kick during the night?	_____	_____	_____	_____	_____
Have cramping in the legs at night?	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs?	_____	_____	_____	_____	_____
Have morning jaw pain?	_____	_____	_____	_____	_____
Grind your teeth during sleep?	_____	_____	_____	_____	_____
Are bothered by pain during the day?	_____	_____	_____	_____	_____
Wake up feeling stiff in the morning?	_____	_____	_____	_____	_____
Wake up feeling sore or achy muscles?	_____	_____	_____	_____	_____
Wake up with pain in the neck, spine, or joints?	_____	_____	_____	_____	_____

30. Does your sleep problem disturb you sex life?

31. What treatment have you received?

32. Do you have a follow-up appointment with your Doctor?
