John D. Bray M.D.
Board Certified in Sleep Medicine
Medical Director
American Academy of Sleep Medicine Accredited Sleep Center
606 North Kent, Ste. B Midland, TX 79701 432-570-NITE (6483), 1-800-915- SLEEP (7533)

Fellow
The American Academy of Allergy & Immunology
The American Academy of Sleep Medicine
The American College of Chest Physicians
The American College of Allergists
The American Academy of Pediatrics

Diplomate
American Board of Allergy & Immunology (Adult & Pediatric)
American Board of Sleep Medicine and Clinical Polysomnography (Adult & Pediatric)
American Board of Medical Specialties in Sleep Medicine (Adult & Pediatric)
American Board of Pediatrics (Pediatric Pulmonology)
American Board of Pediatrics (General Pediatrics)

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SLEEP HISTORY QUESTIONNAIRE

Full Name_____ Date of this Visit_____
Address_____ Date of Birth_____Age_____
_____ Home Phone #_____
_____ Business Phone #_____
Cell Phone #_____
Sex: M F Emergency Contact (who) _____
Emergency Phone #_____ Occupation_____ _____
Who is your physician or healthcare provider? _____
Spouse's Name_____ Referred by_____
*If a Child's; Mother, Father or Guardian's Name, Phone # and Address is different from the child's.
Name: Mother: _____Father: _____
Home Phone: _____ Cell Phone: _____
Full Address: _____

***PLEASE PRINT CLEARLY, ANSWERING CAREFULLY AS BEST YOU CAN. THIS IMPORTANT INFORMATION WILL BE OF GREAT HELP IN LOOKING AFTER YOU PROPERLY.**

FILL IN THE BLANK AND/OR CIRCLE THE ANSWER

CHIEF COMPLAINT

Briefly Describe your main sleep related problem & how long you have had it._____
_____
_____

HISTORY OF THE PRESENT ILLNESS

Tell me more about your problem. _____
_____
_____
_____

Do you snore loudly and frequently? _____

Has your family or friends told you that you stop breathing or have pauses in you breathing when you are asleep that last for 10 or more seconds?_____
After 8 hours in the bed do you still feel tired? _____ Sleepy? _____
Do you have a regular bed partner? **YES** **NO**
If yes, did he or she help you answer these questions? **YES** **NO**
What time do you usually go to bed on weekdays? (i.e.—actually turn out the lights) _____
What time do you usually get out of bed on weekdays? _____
What time do you usually go to bed on weekends? _____
How much do you vary this schedule? _____
Do you work different shifts? _____
What are your normal work hours? _____
On average, how long does it take you to fall asleep after you turn out the lights? _____ Minutes.
Has there been a recent change? **YES** **NO**
As bedtime approaches, which of the following do you feel? (Circle one)
1- Increasingly tense 2- Worried you won't sleep 3- Pleasantly relaxed 4- Unconcerned about sleeping
What goes through your mind as you are falling asleep? _____
_____
On average, how many times do you wake up at night, if at all? _____
What causes you to wake up? _____
On average how long are you awake each time? (Specify minutes) _____
Which term best describes the quality of your sleep? (Circle one) _____
1- Broken 2- Light 3- Deep and restful 4- Sound but with an occasional awakening
On average, how much sleep do you require in order to feel alert and energetic during the day?
(Specify # of hours) _____
On average, how long do you actually sleep? (Specify # of hours) _____
Is it difficult for you to awaken and get out of bed? (i.e.- are you very groggy when you wake up?)
YES **NO**
Do you feel tired and sleepy for more than 15 minutes when you wake up? **YES** **NO**
At what time of the day do you feel least alert? (Specify Hours) _____

SLEEPINESS

Are you often bothered by sleepiness when you want to be awake? **YES** **NO**
If so, describe the time of day and situations when it is the worst: _____
_____

Do you feel sleep, tired, and/or exhausted even after getting a full night's (8 hours) rest in bed?
YES **NO**
Do you involuntarily fall asleep (even briefly) at inappropriate times? **YES** **NO**
If yes, describe briefly_____
Do you feel refreshed afterwards? **YES** **NO**
Do you return to bed or nap after you have awakened for the day? **YES** **NO**
How many times a day do you nap? _____ how long are they? _____
Do you fall asleep in front of the TV, computer, while reading or in the car? **YES** **NO**
Do you have trouble driving? **YES** **NO**

NARCOLEPSY

Have you ever felt you could not move even if you wanted to, either when first falling asleep or when waking up? **YES** **NO**

If yes, when and how often does this occur? _____

Have you ever experienced a sudden, temporary loss of muscle strength, leading to muscle weakness, paralysis, or collapse? **YES** **NO**

If yes, describe. _____

Do you ever sense that you slip into a dream immediately at the onset of sleep, either at night or when you nap? **YES** **NO**

SNORING

Do you have difficulty breathing when lying down or during sleep, especially on your back? **YES** **NO**

Does your breathing ever stop during sleep? **YES** **NO**

Have you ever been told that you snore? **YES** **NO**

Is the snoring interrupted by pauses? **YES** **NO**

Is the snoring and pauses associated with gasping or choking? **YES** **NO**

If you stop breathing or have paused in your sleep, have these occurrences been noted to last 10 seconds or longer? **YES** **NO**

How much did you weigh;

At age 20 _____ 5 years ago _____ 1 year ago _____ Today _____

SLEEP-RELATED LEG SENSATIONS

While lying in bed, have you ever experienced "creeping", "drawing", or other unpleasant sensations in your legs that cause you to want to move them ("nervous leg")? Exclude painful cramps or spasms in leg muscles. **YES** **NO**

SLEEP-RELATED MOVEMENTS

Are you aware or has anyone ever told you that your legs jerk or twitch while you are apparently asleep? **YES** **NO**

Describe any other notable body movements you have, that you or others have observed.

_____

_____

SEIZURE DISORDERS

Have you ever had a seizure?	**YES**	**NO**
Has anyone ever suggested that your movements at night seemed seizure like?	**YES**	**NO**
Have you ever been on seizure medication?	**YES**	**NO**
If you are older than six, do you ever wet the bed at night?	**YES**	**NO**

PARASOMNIAS

Have you, in childhood or currently, ever experienced any of the following phenomena during sleep? If so, put a check mark to the left of those you have experience and complete the information in the columns.

	Times/Week	Age it began	Last occurred	Treatment if any
Talking when apparently asleep				
Sleepwalking				
Grinding teeth when asleep				
Nightmares or Terrors				

PSYCOLOGICAL / SOCIAL HISTORY

Are you under a lot of stress?	**YES**	**NO**
Have you recently lost your job?	**YES**	**NO**
Have you recently had to change jobs?	**YES**	**NO**
Have you lost any loved ones recently?	**YES**	**NO**
Is anyone in your family seriously ill?	**YES**	**NO**
Have you ever seriously considered killing yourself?	**YES**	**NO**
Have you ever had a nervous breakdown?	**YES**	**NO**
Have you ever seen a Psychologist, Psychiatrist, or counselor?	**YES**	**NO**
Do you have significant financial problems?	**YES**	**NO**
Have you taken medication for your nerves?	**YES**	**NO**
Do you get along well with your mate?	**YES**	**NO**
Do you enjoy your family?	**YES**	**NO**
Do you enjoy your life?	**YES**	**NO**
Are you a combat veteran?	**YES**	**NO**
Do you feel you have or may have or need to be treated for PTSD?	**YES**	**NO**
Do you have a spiritual belief system?	**YES**	**N**O
Do you actively participate in it?	**YES**	**NO**
Do you meditate or pray?	**YES**	**NO**

REFLUX

Do you wake with a sour acid taste, or metallic taste?	**YES**	**NO**
Do antacids help your problem and relieve any chest discomfort you have?	**YES**	**NO**
Do you have frequent heartburn?	**YES**	**NO**

ACROMEGALY

Has your shoe size changed within the last 12 months?	**YES**	**NO**
Has your hand size changed within the last 12 months?	**YES**	**NO**

PAST MEDICAL HISTORY

Height _____ inches Weight _____pounds Last physical examination (year)_____

Has your weight changed in the last 12 months? **YES** **NO**

If yes, how many pounds have you gained or lost? _____

What significant health problems have you had or are being treated for now? Please list them all.

_____
_____
_____
_____

Have you had any surgeries? **YES** **NO**

If so, what and when? _____
_____
_____
_____

Are you heterosexual, homosexual, bisexual, non-sexual?

SINUS, THROAT, AND CHEST DISEASE

Do you have Hay Fever, allergies or sinus problems?	**YES**	**NO**
Are you allergic to pollen, dust, animals, grass, hay, etc.?	**YES**	**NO**
Are your sinus problems worse during certain seasons?	**YES**	**NO**
Do you have Asthma?	**YES**	**NO**
Do you have more than one sinus infection a year?	**YES**	**NO**
Do you have recurrent ear infection?	**YES**	**NO**
Have you had frequent bronchitis or recurrent pneumonia?	**YES**	**NO**

Circle any of the following symptoms you have:

Nose: Sneezing Running Plugging Itching

Mouth Breathing Sinus Pressure Sinus Headaches

Have you ever broken your nose? If yes when? _____

Have thick infected discharge

Ears popping fullness fluid in ears tubes ruptured ear drum
Fluid or mucus coming out of ears

Throat: Soreness Post Nasal Drip Roof of mouth itches

Chest: Cough Pain Wheezing Tightness

Shortness of breath at rest on exertion

Sputum Color Amount Any Blood

CARDIAC AND CARDIAC RELATED

Have you ever had any heart problems? (Example; Heart Attack)	**YES**	**NO**
Does your heart beat irregularly?	**YES**	**NO**
Have you ever had a stroke?	**YES**	**NO**
Do you have Diabetes?	**YES**	**NO**
Do you have hypertension? (High blood pressure)	**YES**	**NO**
Is your cholesterol high?	**YES**	**NO**

FAMILY SLEEP HISTORY

Has anyone in your family ever had a sleeping problem, daytime sleepiness, or loud snoring? If yes, please complete the items below for affected family members.

Family Member	Type of Problems	Suggested Treatment	Treating Dr. Clinic or Hospital	When Treated if ever (year)

FAMILY HEALTH HISTORY

For each family member, indicate current age or age at death, present state of health (good, poor) or cause of death as well as major illnesses.

	If living Age/Health	If deceased Age/Cause	Medical Problem/Illnesses
Father			
Mother			
Brothers			
Or			
Sisters			
Children			

What diseases seem to be common in your close blood relative? Please list them. _____

_____

ENVIRONMENTAL HISTORY

Where were you born? _____

How long have you lived in West Texas? _____

What type of work do you currently do? _____

Have you been repeatedly exposed to potent chemicals or industrial dust? **YES** **NO**

Were you or are you in the military? **YES** **NO** if so, what branch? _____

Were you exposed to any significant chemicals? **YES** **NO** If so, what chemicals? _____

Were you directly involved in combat? **YES** **NO** When_____ Where_____ How Much _____

Does anyone smoke in the house? **YES** **NO** Who? _____

Do you have any animals in the house? **YES** **NO** If yes what type? _____

Do you have water damage or mold in the house? **YES** **NO**

Have you had recent problems with mice or cockroaches? **YES** **NO**

Do you have house plants? **YES** **NO**

Is your house dusty? **YES** **NO**

Do you have carpet in your house? **YES** **NO** If yes which room?_____

ALLERGIES TO FOODS

Do any foods seem to cause a rash or hives, make your mouth itch or swell, nose run, give you headaches, make your stomach cramp, give you diarrhea, make you cough or wheeze? **YES** **NO**

If yes, which foods/symptoms? _____

_____

_____

ALLERGIES TO MEDICATIONS

Are you allergic to any medication? **YES** **NO**

If yes, please list. _____

_____
_____

IMMUNIZATIONS

Are you up to date on immunizations?	**YES**	**NO**	**DON'T KNOW**
Have you had a flu shot this flu season?	**YES**	**NO**	
Have you had a Pneumonia shot?	**YES**	**NO**	**When? _____**

PHYSICAL AGENTS AND HABITS

List the amounts of the following beverages you consume. If not used every day, list in the far right column the average per week.

	Daily	**After 6pm**	**at Bedtime**	**Weekly**
Coffee (cups)				
Tea (glasses or cups)				
Carbonated Drinks (Cans or bottles)				
Beer, wine, liquor (Cans, bottles, ounces)				

Cigarettes _____ packs or parts of pack per day. How many years of smoking? _____
If you have quit smoking, when _____
Chewing tobacco or snuff for _____years. Cigars _____per day Years smoked _____
Do you smoke marijuana? **YES** **NO** Number of joints per day _____
Do you take (non doctor prescribed) pills or inject any drugs? **YES** **NO**
If yes what type? _____
Have you ever had a drinking problem? **YES** **NO**
Have you used drugs in the past? **YES** **NO**
Do you do any regular exercise? **YES** **NO**
What type? _____
How often? _____ How long at a time _____

MEDICATIONS

Are you on a blood thinner? **YES** **NO**
If yes what medication? _____

Apart from sleep medications, name all other medications you are currently taking.
(Prescribed or otherwise)

Medication Name	**Dose**	**Times Daily**	**Reason**	**How long used?**	**Doctor**

_____
_____

Do you use any vitamins, herbs, food supplements or steroids? **YES** **NO**
If yes, please list them: _____
_____
_____
_____

IMPORTANT: AUTO, TRUCK OR WORK RELATED ACCIDENTS

Do you feel that your sleep problems may have caused or contributed to having an accident? **YES** **NO**
If yes, explain _____
_____
Have you had any accidents in the past 5 years? **YES** **NO**
If yes, explain: _____
_____
Have you had any near misses? **YES** **NO**
If yes, explain: _____
_____
WOMEN: Are you pregnant? _____ When was your last menstrual period? _____

REVIEW OF SYSTEMS- FINAL REVIEW AND SUMMARY OF YOUR HEALTH:
List the health problems you have had in the past or still have:

SYSTEM	Type of problem	Date	Treating Dr., Clinic or Hospital

Respiratory Conditions: _____
_____
_____

Psychological/ Psychiatric: _____
_____
_____

Eyes, Ears, Throat, Mouth: _____
_____
_____

Nasal (sinusitis, obstruction, deviated septum, sinus allergy problems):
_____
_____
_____

Heart, Circulation, Blood Pressure: _____
_____
_____

Stomach, Digestive, Intestinal Disorders, Hepatitis: _____
_____
_____

Kidney, Urological or Sexual

Disorders/Dysfunctions: _____
_____
_____

Head/Nervous Systems
(Head trauma, convulsions, Strokes, spinal problems, nerve problems):_____
_____
_____

Skin disorders: _____
_____
_____

Blood disorders: _____
_____
_____

Problems with your Immunity: _____
_____
_____

Hormonal problems: _____
_____
_____

Bone, Joint, Muscle problems: _____
_____

Surgical operations: _____
_____
_____

Accidents, Injuries: _____
_____
_____

Other problems: _____
_____
_____

Is there any other information about you and your medical history that you think is important?
_____
_____
_____

If you were referred to me by a medical provider please give me that person's name and degree: MD, Nurse Practitioner, N.P. or Physician's Assistant, P.A. I will provide them with a follow up letter about your problem and my recommendations.

Name: _____ Address: _____

Phone Number: _____

THANK YOU FOR BEING THOROUGH IN FILLING OUT THIS DETAILED, SLEEP MEDICAL HISTORY!

OBTAINING A GOOD COMPLETE MEDICAL HISTORY IS FAR AND AWAY THE MOST IMPORTANT THING A PHYSICIAN CAN DO TO MAKE A PROPER DIAGNOSIS. EVERYTHING THAT FOLLOWS IN YOUR CARE DEPENDS ON ITS QUALITY. YOUR HELP WITH THIS WILL GREATLY ASSIST ME AS I STRIVE TO PROVIDE YOU WITH EXCELLENT MEDICAL CARE.

JDB/mlb