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# SLEEP HISTORY QUESTIONNAIRE

Full Name____________________
Address______________________
______________________
______________________
Sex:   M      F
SS#_________________________
Occupation___________________
Spouse's Name________________

Date of Visit__________________________
Date of Birth__________________________
Home Phone #_________________________
Business Phone #______________________
Cell Phone #___________________________
Emergency Contact (who) ________________
Emergency Phone #_____________________
Who is your physician? ___________________
Referred by_____________________________

*If a Child's; Mother, Father or Guardian's Name, Phone # and Address is different from the child's.
Name: _______________________________________________ Phone: __________________________
Full Address: __________________________________________________________________________

## *PLEASE PRINT CLEARLY, ANSWERING CAREFULLY AS BEST YOU CAN. SOME MAY NOT APPLY TO YOU AND SOME YOU MAY WANT TO DISCUSS WITH DR. BRAY IN PRIVATE*

## 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? ____________________ Explain briefly ________________
______________________________________________________________________________________

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? __________________________

How long have you had this problem? ______________________________________________________________

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? _____________________
What time do you usually get out of 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

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________________________________________________________________________

How long do these sleep episodes usually last? (Specify minutes) ______________________

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

## 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? 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

Is your snoring loud enough to disturb:

a. A bed partner or someone in the same room? YES NO

b. Someone in another room? YES NO

c. Do you sleep alone in your house or apartment? 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 | | | | |
| Disturbing dreams | | | | |
| Nightmares | | | | |
| Waking up screaming and afraid in the first 3 hours of sleep | | | | |

## PSYCOLOGICAL / SOCIAL HISTORY

| | | |
|---|---|---|
| Are you under a lot of stress? | YES | NO |
| Have you been divorced in the last 3 years? | 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 |
| Have you been in the military? | YES | NO |
| Are you a combat veteran? | YES | NO |
| Do you feel you have or may have been treated for PTSD? | YES | NO |
| Do you have a spiritual belief system? | YES | NO |
| 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 a hiatal hernia? | YES | NO |
| Do you have frequent heartburn? | YES | NO |
| Do you vomit easily? | 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)__________

| | | |
|---|---|---|
| Are you generally in good health as far as you know? | YES | NO |
| 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? | 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 recurrent sinusitis? | 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

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 do? ____________________________________________________________
Have you ever been repeatedly exposed to chemicals or industrial dust? YES NO
If so, what? ___________________________________________________________________________
Does anyone smoke in the house? YES NO
Pets: Dog Cat other ________________ How long?__________
Were you in the military service? YES NO
If yes, how long? ________________________________________________________________________
What did you do in the military? ___________________________________________________________
Did you see any significant combat? _________________________________________________________

**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
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 | Dose | Times | Reason | How long used? | Doctor |
|---|---|---|---|---|---|

Name Daily

List all medications that you have ever taken for sleep problems, starting with any currently used medicines. (Prescribed or non-prescribed)

| Medication Name | Dose | Times Daily | Helpful | How long used? | Take it Now? | When Stopped? | 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 (sinus, obstruction,
Allergy): ____________________________________________

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

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?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Do you have a primary care physician? **YES** **NO** If yes please provide Dr. Bray with the information below:

Name: ________________________________ Address:___________________________________

Phone Number: _______________________________

Did your primary care physician, physician's assistant, nurse practitioner or any other medical professional refer you to Dr. Bray? **YES** **NO**

If yes please provide the name, address and phone number if different than the above. Dr. Bray will provide the medical professional who referred you with a referral letter.

Name:__________________________________Address:_________________________________

Phone Number: ________________________________________

**THANK YOU** OR BEING THOROUGH IN FILLING OUT THIS DETAILED, SLEEP MEDICAL HISTORY

**OBTAINING A GOOD 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.**

JDB/mlb