Sleep Questionnaire

Phone: (440) 285-9598
Fax: (440) 286-9594

General Questionnaire

Patient Name: _____ Date: _____

YEAR	LIST ALL PAST ILLNESSES & SURGERIES	PLACE HOSPITALIZED

HAVE YOU EVER HAD?

	High blood pressure	Deviated septum	
	Phlebitis or blood clots	Sinus congestion	
	pneumonia	Seizure/epilepsy	
	diabetes	depression	
	polio	ulcer	
	Heart murmur	anxiety	
	Heart attack	Migraine/headaches	
	stroke	asthma	
	Nose broken	Thyroid disease	
	Chronic lung disease		

ALLERGIES

	MEDICATION/SUBSTANCE	REACTION		MEDICATION/SUBSTANCE	REACTION
1			4		
2			5		
3			6		

MEDICATIONS TAKEN NAME	DOSE (MG)	TIMES/DAY	NAME	DOSE (MG)	TIMES/DAY

FAMILY HISTORY:
List all children, parents and all brothers and sisters (names not needed). If deceased, please list age at death and cause of

	LIVING?	AGE	ANY KNOWN MEDICAL CONDITIONS OR CAUSE OF DEATH
CHILDREN:			
FATHER			
MOTHER			
SIBLINGS			

WHICH OF THE FOLLOWING ARE PRESENT IN A BLOOD RELATIVE?

	stroke	Tuberculosis	
	Heart attack / angioplasty	Asthma / emphysema	
	Heart surgery	glaucoma	
	High blood pressure	arthritis	
	diabetes	Liver problems	
	High cholesterol/triglyceride	Thyroid disease	
	aneurysm	Migraine/headaches	
	hepatitis	migraines	
	alcoholism	epilepsy	
	aneurysm	Other _____	

PERSONAL HABITS:

Do you smoke? *Y* *N* Packs per day? _____
Did you ever smoke? *Y* *N* When did you stop?_____

DO YOU TRAVEL OUTSIDE OHIO? *Y* *N*

DO YOU EXERCISE? *Y* *N* HOW OFTEN?_____
WHAT TYPE?_____

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NAME: _____ DATE: _____

What type of sleep symptoms are you experiencing?

- ☐ Excessive or loud snoring
- ☐ Daytime sleepiness
- ☐ Sleep walking
- ☐ Thrashing about in sleep
- ☐ Legs jerk/kick at night
- ☐ Uncomfortable legs at night
- ☐ Difficulty falling asleep
- ☐ Bed wetting
- ☐ Night terrors
- ☐ Paralysis in sleep
- ☐ Hallucinations
- ☐ Acting out dreams
- ☐ Other unusual behavior
- ☐ Gasping episodes
- ☐ Oth-

How many years have you been having these symptoms? _____

How many nights per week would you say your sleep is poor? _____

Have you ever undergone any of the following treatments?

- ☐ lithium
- ☐ Pain pills
- ☐ tranquilizers
- ☐ antidepressants
- ☐ Heart pills
- ☐ stimulants
- ☐ electroshock
- ☐ acupuncture

How much sleep do you usually get each night? _____

How long does it usually take to fall asleep? _____

How many times do you usually wake up during the night? _____

What time do you usually go to bed during the week? _____

What time do you usually go to bed on the weekend? _____

What time do you usually get up during the week? _____

What time do you usually get up on the weekends? _____

Do you work different shifts? _____

On average, how much caffeine do you drink per day? _____

On average, how much alcohol do you consume per day? _____

Do you take any over the counter sleep aids? _____

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Do you have any of the following symptoms?

☐ YES	☐ NO	FATIGUE?
☐ YES	☐ NO	WEAKNESS, NUMBNESS, TINGLING OF ARMS OR LEGS?
☐ YES	☐ NO	NEW, FREQUENT OR SEVERE HEADACHES?
☐ YES	☐ NO	FALLS, IMBALANCE OR DIFFICULTY WALKING?
☐ YES	☐ NO	LOSS OF CONSCIOUSNESS, FAINTING OR CONVULSIONS?
☐ YES	☐ NO	LOSS OF MEMORY OR CONFUSION?
☐ YES	☐ NO	PROBLEMS WITH VISION OR EYES?
☐ YES	☐ NO	CHANGE IN HEARING?
☐ YES	☐ NO	DO YOU WEAR A HEARING AID?
☐ YES	☐ NO	CHANGE IN SPEECH OR VOICE?
☐ YES	☐ NO	DIZZINESS?
☐ YES	☐ NO	FREQUENT OR SEVERE NOSEBLEEDS?
☐ YES	☐ NO	TROUBLE CHEWING OR SWALLOWING?
☐ YES	☐ NO	SORE TONGUE OR MOUTH OR DENTAL PROBLEMS?
☐ YES	☐ NO	DAILY COUGH, OR COUGH WITH BLOODY PHLEGM?
☐ YES	☐ NO	SHORT OF BREATH AFTER WALKING UP TWO FLIGHTS OF STAIRS?
☐ YES	☐ NO	SHORTNESS OF BREATH WHEN JUST SITTING OR RECLINING?
☐ YES	☐ NO	DISCOMFORT, PAIN, PRESSURE IN CHEST?
☐ YES	☐ NO	SWELLING OF THE ANKLES EVERY DAY?
☐ YES	☐ NO	PAIN OR TIREDNESS IN THE LEGS WHILE WALKING?

PLEASE CONTINUE ON OTHER SIDE

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Do you have any of the following symptoms? (Continued)

☐ YES	☐ NO	HIGH BLOOD PRESSURE?
☐ YES	☐ NO	FREQUENT HEARTBURN OR INDIGESTION?
☐ YES	☐ NO	CHANGE IN BOWEL HABITS?
☐ YES	☐ NO	DIFFICULTY URINATING?
☐ YES	☐ NO	DO YOU LOSE CONTROL OF URINE AT TIMES?
☐ YES	☐ NO	AWAKE AT NIGHT MORE THAN ONCE TO URINATE?
☐ YES	☐ NO	SEXUAL PROBLEMS OR CHANGE IN SEX DRIVE?
☐ YES	☐ NO	ANY SKIN CHANGES?
☐ YES	☐ NO	PERSISTENT PAINFUL, STIFF OR SWOLLEN JOINTS?
☐ YES	☐ NO	BACK PAIN OR DISCOMFORT?
☐ YES	☐ NO	DO YOU ENJOY YOUR WORK?
☐ YES	☐ NO	ANY STRESS OR CONFLICTS AT WORK?
☐ YES	☐ NO	ANY STRESS OR CONFLICTS AT HOME?
☐ YES	☐ NO	ANXIOUS OR DEPRESSED MUCH OF THE TIME?
☐ YES	☐ NO	EVER HOSPITALIZED FOR AN EMOTIONAL PROBLEM?
☐ YES	☐ NO	ARE MENSTRUAL PERIODS NORMAL?
☐ YES	☐ NO	BLEEDING BETWEEN PERIODS OR AFTER MENOPAUSE?
☐ YES	☐ NO	ANY HOT FLASHES?
☐ YES	☐ NO	HAVE YOU USED HORMONES?
☐ YES	☐ NO	HAVE YOU EVER BEEN PREGNANT?