Patient Medical and Sleep History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Email:**_____

Address: _____ **City, State:** _____ **Zip:** _____

Primary/Alternate Phone: _____ **Emergency Contact/Number:**_____

Social Security Number: _____ **Referring Physician:** _____

Height: _____ **Weight:** _____ **Neck Size:** _____

Please circle: Male/Female **Race:** _____ **Marital Status:** _____

Please List all medications that you are currently taking.

Allergies _____ **Pharmacy**_____

Current symptoms or illnesses_____

Medical History (Have you ever been diagnosed with any of the following? Check all that apply)

- ☐ Asthma
- ☐ Anxiety Disorder (anxiety attacks)
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hypothyroidism
- ☐ Kidney Failure
- ☐ Peptic Ulcer
- ☐ Menopause
- ☐ Cancer
- ☐ Allergies
- ☐ Arthritis
- ☐ COPD
- ☐ Deviated Septum
- ☐ Emphysema
- ☐ GERD – Gastro Esophageal Reflux
- ☐ Hyperthyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Seizures
- ☐ Prostate Disease

Other:

_____

_____

Cardiovascular History (Have you ever been diagnosed with any of the following? Check all that apply)

- ☐ Angina
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Balloon Angioplasty or Stents
- ☐ Cardiac Surgery for Coronary Bypass
- ☐ Cortication of the Aorta
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diastolic Dysfunction
- ☐ Enlarged Heart
- ☐ Heart Attack – Myocardial Infarction
- ☐ High Cholesterol
- ☐ Chest Pain
- ☐ Hyperlipidemia
- ☐ Hypertension (High blood pressure treated or untreated)
- ☐ Internal Defibrillator
- ☐ LVH – Left Ventricular Hypertrophy
- ☐ Microalbuminuri
- ☐ Nocturnal Ischemia
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ Stroke or TIA
- ☐ Ventricular Arrhythmia
- ☐ Cardiac Surgery for valve replacement

List any other Cardiovascular Conditions that you have or have had in the past. _____

_____

_____

Surgical History (Have you ever had any of the following surgical procedures? Check all that apply.)

- ☐ Deviated Septum
- ☐ Gastric Bypass
- ☐ Hip Replacement
- ☐ Herniated Disk Repair
- ☐ Knee Replacement
- ☐ Spinal Fusion
- ☐ Tonsillectomy
- ☐ Repair of broken bone
- ☐ UPPP
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Lung transplant
- ☐ Kidney Transplant
- ☐ Heart Valve Replacement
- ☐ Coronary Bypass Surgery (CABG)

Please list any other surgical procedures that you have had. _____

_____

_____

Past Sleep Diagnosis - In the past have you been diagnosed with any of the following? Please check all that apply.

- ☐ Sleep Apnea
- ☐ Periodic Limb Movement
- ☐ Insomnia
- ☐ Restless Legs Syndrome
- ☐ Narcolepsy
- ☐ Seizures

Have you had a sleep study preformed in the past? _____Yes _____No

If so, where?_____

How long ago? _____

Home Care:

Do you currently have a CPAP machine in your home? _____YES _____NO
If so, how many hours per night are you wearing your CPAP mask?_____
Do you have oxygen in your home? _____YES _____NO
How many hours per day are you wearing oxygen? ____During hours of sleep?___ During daytime?____
Do you require the use of any special equipment/devices such as a wheelchair or lift, etc.?___YES___NO
If yes, explain_____

Family History (Have any of your blood relatives ever been diagnosed with any of the following? Check all that apply.)

- ☐ Premature Cardiovascular Death (died from heart disease when they were younger than 70 years of age)
- ☐ Stroke or TIA
- ☐ Sudden Cardiac Death
- ☐ Heart Attack
- ☐ Coronary Artery disease
- ☐ Narcolepsy
- ☐ Arrhythmia
- ☐ Congestive Heart Failure
- ☐ Obstructive Sleep Apnea
- ☐ Died in their sleep

Current Sleep Schedule:

During the Week

What time do you normally go to bed on weeknights? _____
What time do you normally get out of bed on weekdays? _____
Do you nap on weekdays? _____ What time do you nap? _____
How long are your naps? _____

On Weekends

What time do you normally go to bed on weekends? _____
What time do you get out of bed on weekends? _____
Do you nap on weekends? _____ What time do you nap?_____
How long are your naps? _____

Sleep Habits

Do you watch television in bed prior to going to sleep? _____
How long is the television left on? _____ hrs. _____ all night
Do you read in bed prior to sleeping? _____
How long do you read in bed prior to turning the lights off? _____

Generally speaking, your challenges with going to sleep at night are related to. (Check all that apply)

- ☐ Temperature in bedroom.
- ☐ Assisting others
- ☐ Pets
- ☐ Pain or discomfort
- ☐ Restless Legs (creepy crawly feelings in your legs)
- ☐ Thoughts running through your mind
- ☐ Inability to settle down
- ☐ Going to bed prior to being sleepy
- ☐ Anxiety
- ☐ Fear of not being able to go to sleep or not being able to get enough sleep
- ☐ Bed Partner Activities (snoring, reading, lights on, TV on, restless sleep, etc)
- ☐ Noise
- ☐ Telephone
- ☐ Uncomfortable Bed