



**Patient Medical History** Page One

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs Race: \_\_\_\_\_

Gender:  M  F Marital Status:  Single  Married  Divorced  Widowed Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Sleep Complaint: \_\_\_\_\_

**Past Medical History** Please answer all questions to the best of your ability.

Do you now or have you ever had :

Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (Blood sugar high or low)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peptic Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain all "Yes" answers:

\_\_\_\_\_  
\_\_\_\_\_

**Habits**

Do you now or have you ever used:

1. Tobacco ( smoke cigarettes, chew tobacco, etc.)  Yes  No If yes, indicate amount per day: \_\_\_\_\_  
If yes, how long? \_\_\_\_\_ years Have you quit?  Yes  No If yes, when? \_\_\_\_\_

2. Alcohol (beer, liquor, wine, etc.)  Yes  No If yes, indicate amount per day: \_\_\_\_\_  
If yes, how long? \_\_\_\_\_ years Have you quit?  Yes  No If yes, when? \_\_\_\_\_

3. Caffeinated beverages (soda, coffee, tea, etc.)  Yes  No If yes, indicate amount per day: \_\_\_\_\_  
Have you quit?  Yes  No

**Medications**

Please list all medications you are currently taking. Please bring your packages/bottles with you to your appointment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Please list medication allergies: \_\_\_\_\_

**Operations**

Please list any operations you have had:

	Date	Hospital	Doctor
Tonsillectomy	_____	_____	_____
Gallbladder	_____	_____	_____
UPPP	_____	_____	_____
Other	_____	_____	_____

Are you in good health now?  Yes  No If no, please describe your current health conditions/illnesses: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Continued...



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have:

- |                                   |                          |     |                          |    |                                       |                          |     |                          |    |
|-----------------------------------|--------------------------|-----|--------------------------|----|---------------------------------------|--------------------------|-----|--------------------------|----|
| Frequent or severe headaches      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Frequent cough                        | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Difficulty breathing through nose | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Chronic nasal discharge               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Painful sinuses                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Shortness of breath                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Allergies/Hayfever                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Asthma or wheezing                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dentures                          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Emphysema                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Smothering spells at night        | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Swollen legs                          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Irregular heart beat              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart enlargement                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Chest pain with exercise          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you sleep on more than one pillow? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Difficulty swallowing             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heartburn                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Voice changes/ hoarseness         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Hiatal hernia                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Comments: (Please explain all 'yes' answers)

\_\_\_\_\_

- |                               |                          |     |                          |    |                                 |                          |     |                          |    |
|-------------------------------|--------------------------|-----|--------------------------|----|---------------------------------|--------------------------|-----|--------------------------|----|
| Chronic muscular pain         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Pain in joints                  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Localized muscle weakness     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Arthritis                       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Goiter or thyroid enlargement | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | High blood sugar                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Weight loss                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Abnormal glucose tolerance test | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Weight gain                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Low blood sugar                 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Low blood pressure            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | HIV or AIDS                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Anemia (low hemoglobin)       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |                                 |                          |     |                          |    |

Comments: (Please explain all 'yes' answers)

\_\_\_\_\_

- |  |                          |     |                          |    |                             |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|-----------------------------|--------------------------|-----|--------------------------|----|
| History of Stroke                                  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Personality changes         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Memory loss  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Diagnosed Depression        | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Difficulty moving or controlling part of your body | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Difficulty sleeping         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Tremors or shakes in your arms or legs             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | "Drop" or paralysis attacks | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
|  |                          |     |                          |    | Difficulty speaking         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Comments: (Please explain all 'yes' answers)

\_\_\_\_\_

**Sleep Assessment**

The following questions will help us to obtain an understanding of your sleeping problems. It is extremely important that you answer these questions as completely as possible. There are some questions that your bedpartner or room-mate can be helpful with, such as snoring questions.

Do not spend too much time on these questions: your first impression is the best answer in most cases. Answer all questions by considering the past six months, unless otherwise specified. If you are engaged in shift work or other unusual sleep/wake schedule, refer to 'Daytime' as the times you would normally be awake, and 'Nighttime' when you would be sleeping.

- How many miles do you drive to work each day? \_\_\_\_\_ Approximately how many miles per year do you drive? \_\_\_\_\_
- On a scale of 1 to 10, with 10 being the worst or most problem, how much does sleepiness affect your: (circle one number)  
driving performance? 1 2 3 4 5 6 7 8 9 10 work performance? 1 2 3 4 5 6 7 8 9 10
- Have you had driving accidents or 'near miss' incidents while driving related to sleepiness?  Yes  No
- If the answer to number 3 is yes, How many accidents have you had due to sleepiness? \_\_\_\_\_  
How many near miss incidents have you had due to sleepiness? \_\_\_\_\_
- What shift do you normally work? \_\_\_\_\_ Day / 1st \_\_\_\_\_ Evening / 2nd \_\_\_\_\_ Night / 3rd \_\_\_\_\_ Swing
- How many work related mistakes per year do you have associated with sleepiness? \_\_\_\_\_ Fatigue? \_\_\_\_\_
- How many work related accidental injuries per year do you have associated with sleepiness? \_\_\_\_\_ Fatigue? \_\_\_\_\_
- Do you normally work more than 40 hours per week?  Yes  No

Do you feel that you:

- get too little sleep at night  Yes  No
- get too much sleep at night  Yes  No

Continued...



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

<i>How much of a problem do you have:</i> <small>(check box of best answer)</small>	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe/ Always
11. with going to sleep at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. because of waking up during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. not feeling rested, no matter how much sleep you get	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. with tiredness, not sleepiness, during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. with sleepiness during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. On a **weekday**, what time do you usually ...  
 Go to bed: \_\_\_\_\_am/pm      get up: \_\_\_\_\_am/pm  
 Do you normally take naps:                       Yes     No  
 If yes, how many per day? \_\_\_\_\_      What time(s)? \_\_\_\_\_  
 How long does your typical nap last? \_\_\_\_\_minutes / hours

17. On a **week-end or day off**, what time do you usually ...  
 Go to bed: \_\_\_\_\_am/pm      get up: \_\_\_\_\_am/pm  
 Do you normally take naps:                       Yes     No  
 If yes, how many per day? \_\_\_\_\_      What time(s)? \_\_\_\_\_  
 How long does your typical nap last? \_\_\_\_\_minutes / hours

18. Do you watch TV or read in bed before going to sleep?     Yes     No  
 If yes, how long? \_\_\_\_\_

19. Do you use sleeping aids or medicine?                       Yes     No  
 If yes, please list: \_\_\_\_\_ how often do you use it? \_\_\_\_\_

20. How long are you in bed before deciding to go to sleep?      \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 21. How long does it take you to fall asleep after you have decided to?      \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 22. How many hours of sleep do you get in a typical night?      \_\_\_\_\_ hours  
 23. How many times do you wake up in a typical night?      \_\_\_\_\_ times  
 24. How long is a typical wake time?      \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 25. If you do awaken during your sleep, which part(s) of the night is it likely to happen?  
       \_\_\_\_\_ First third    \_\_\_\_\_ Second third    \_\_\_\_\_ Last third  
 26. How many times do you get out of bed in a typical night?      \_\_\_\_\_ times  
 27. How long is the typical time out of bed during the night?      \_\_\_\_\_ hours \_\_\_\_\_ minutes

<i>When falling asleep, how often do you:</i> <small>(check box of best answer)</small>	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe Always
28. Have thoughts racing through your mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Feel sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have anxiety, or worry about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Feel muscular tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Feel afraid of not being able to go to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Feel unable to move or paralyzed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Notice parts of your body startle or jerk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Experience restlessness in your legs (crawling or aching, unable to keep your legs still)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Experience vivid, dreamlike scenes or hallucinations even though you are awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Experience pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued...



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Sleep Assessment (continued)**

	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe/ Always
<i>During the night, how often do you:</i>					
38. Sleep with someone else in your room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Sleep with someone else in your bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Sleep on a special surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
41. Have restless, disturbed sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Disturb the sleep of your bed partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Provide assistance to someone or something else during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
44. Have nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Use nasal spray or other medication to deal with nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
46. Snore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Hold your breath or stop breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Wake up gasping for air or feeling you can't breathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Wake with a choking sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Have some other breathing problem during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
51. Sweat excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Sleep walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Sleep talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
54. Grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Have leg twitching or jerking during your sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Have other unusual movements during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Eat during the night after you go to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
<i>During the night, how often is your sleep disturbed because of:</i>					
58. Stomach or abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Parasthesia (pins and needles sensation) in your arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Itching sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
62. Feeling short of breath in a flat position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. 'gas' in your stomach, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Awakenings with regurgitation, or burning in your throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
67. Awakenings with the urgent need to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Intense heart pain (angina)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Other chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
70. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. Persistent coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
72. How long does it take you to "get going" in the morning? _____ minutes					
.....					
73. How often do you feel extremely alert and energetic all day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you! Please bring this form with you to your appointment!**