Spartanburg Regional

Sleep Services – North Grove

Original Date:	2/22/09
Dates Revised:	9/6/11

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other	
Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American/Alaskan Native ☐ Other	
Previous or referring doctor:	**Date of last physical exam:**

ACUTE SLEEP SYMPTOMS	
What is your main sleep problem?	
How long has this been a problem?	☐ last 3 months ☐ last 6 months ☐ last year ☐ more than 1 yr ☐ I don't remember
Is this problem:	☐ getting worse ☐ getting better ☐ staying the same

CLINICAL DATA QUESTIONS		
Are you currently taking any blood pressure medications? If "Yes", how many? ☐ 1 ☐ 2 ☐ 3 ☐ 4	**☐ Yes**	**☐ No**
Have you ever taken a sleeping pill (prescription or OTC)?	**☐ Yes**	**☐ No**
If yes, what and when:		
Do you use tobacco?	**☐ Yes**	**☐ No**

Have you ever been diagnosed with the following?

☐ Coronary Artery Disease	**☐ Atrial Fibrillation**	**☐ Pacemaker**
☐ Congestive Heart Failure	**☐ Diabetes**	**☐ Internal Defibrillator**
☐ Stroke	**☐ TIA (mini stroke)**	

PERSONAL HEALTH HISTORY						
Allergies: (Please list any food, medication or environmental allergies *and* the reaction you had.)						
Physical Information:	Height:		Weight:		Neck Size:	
How would you currently describe your health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor					

Check any medical problems that other doctors have diagnosed		
☐ Alcoholism	☐ Depression	☐ Obesity
☐ Allergies	☐ Drug addiction	☐ Overweight
☐ Anxiety	☐ Edema, pedal	☐ Post-MI
☐ Arthritic pain	☐ Fainting	☐ Postural hypertension
☐ Asthma	☐ Head trauma	☐ Reflux / heartburn
☐ Attention deficit disorder	☐ Heart problems	☐ Retroagnathia
☐ Back problems	☐ High cholesterol	☐ Shortness of breath
☐ Chronic hypercapnea / hypoxemia	☐ Hormonal problems	☐ Sinus problems
☐ Cold extremities	☐ Hypertension	☐ TMJ
☐ COPD	☐ Impotence	☐ Tonsillectomy
☐ Cor Pulmonale	☐ Nasal obstruction	☐ Upper respiratory infections, recurring

➢ **Have you ever had a Sleep Study before?** Yes or No

➢ If so, **where & when**? _____

Surgeries		
Year	Reason	Hospital
Other Hospitalizations		
Year	Reason	Hospital
Medications – Please complete Attached Universal Medication List at end of this packet.		

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3= high chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____ Total: _____

SLEEP HISTORY AND CURRENT SLEEP HABITS

During your sleep, do you currently have or in the last 6 months have had any of the following problems? (Please check all that apply)

☐ Stop breathing in your sleep	☐ Frequent arousals from sleep	☐ Dry mouth at night
☐ Difficulty initiating / maintaining sleep	☐ Drooling at night	☐ Morning headaches
☐ Excessive daytime sleepiness	☐ Morning fatigue	☐ Nightmares/Night terrors
☐ Leg discomfort before falling asleep	☐ Leg cramps while asleep	☐ Shortness of breath when lying down
☐ Frequent trips to the bathroom	☐ Loud snoring	☐ Restless sleeper
☐ Palpitations at awakening	☐ Sleep walking/talking	☐ Night sweats
☐ Heartburn /gas pains	☐ Gasping/Choking sensation	☐ Cold extremities

What is your usual bed time?	What is your usual rise time?		
Have you ever hurt yourself during sleep?		☐ Yes	☐ No
Have your movements during sleep ever hurt others?		☐ Yes	☐ No
Have you ever had a sleep study?		☐ Yes	☐ No
If yes, where and when:			
Do you sleep alone?		☐ Yes	☐ No
If no, who sleeps in bed with you:	☐ Spouse ☐ Significant Other ☐ Child/Parent ☐ Pet		
How would you describe your sleep?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor		
How would you describe your bed partner's sleep?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor		
How regular are your sleep habits?	☐ Very Regular ☐ Usually Regular ☐ Usually Irregular ☐ Very Irregular		
How long does it usually take you to fall asleep?	☐ 0-10 min ☐ 11-20 min ☐ 21-30 min ☐ 31-60 min ☐ more than 60 min		
How many times do you wake up during an average night?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5		
When you wake up during the night, how long does it usually take you to fall back to sleep?			
How long does it usually take you to fall asleep?	☐ 0-10 min ☐ 11-20 min ☐ 21-30 min ☐ 31-60 min ☐ more than 60 min		
If you can't fall back to sleep do you get out of bed?		☐ Yes	☐ No
Do you watch television or listen to music to help you fall asleep?		☐ Yes	☐ No
How many hours of sleep do you get each night on the average?	☐ 5hrs or less ☐ 6 hrs ☐ 7 hrs ☐ 8 hrs ☐ 9 hrs ☐ more than 9 hrs		
Do you keep the same schedule on weekends or days off work?		☐ Yes	☐ No
How often is your sleep disrupted by discomfort or pain?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5		
Please describe your normal work hours.			
If you do shift work, how often does your shift change?			

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	# Of meals you eat in an average day?		

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?			
	How many drinks per week? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ more than 8			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

DAYTIME FUNCTIONING		
Do you feel FATIGUE (tiredness, exhaustion, lethargy) in the daytime even when you are not sleepy?	☐ No ☐ Infrequently ☐ Occasionally ☐ Often ☐ Always	
Do you feel SLEEPY (or struggle to stay awake) in the daytime?	☐ No ☐ Infrequently ☐ Occasionally ☐ Often ☐ Always	
If so under what circumstances do you fall asleep easily? (check all that apply)	☐ Driving ☐ After Meals ☐ Meetings/Class/Church ☐ Reading/Watching TV ☐ Other	
Does your daytime sleepiness interfere with: (Please check all that apply)	☐ Household Chores ☐ Relationships ☐ Job Performance ☐ School	
Have you ever had an accident or near miss from falling asleep while driving?		☐ Yes ☐ No
How often do you feel alert and energetic for an entire day?	☐ Never ☐ Sometimes ☐ Most of the time ☐ All the time	
Do you take naps (intentional or unintentional) during the day?		☐ Yes ☐ No
If so how often and for how long?		
Do you feel refreshed after naps?		☐ Yes ☐ No

MOOD AND COGNITION		
Has your memory been getting worse lately?		☐ Yes ☐ No
Have you had difficulty concentrating lately?		☐ Yes ☐ No
Have you been feeling more irritable lately?		☐ Yes ☐ No
Have you ever been treated for anxiety, depression or severe stress?		☐ Yes ☐ No
Please explain:		
Have you been feeling more depressed lately?		☐ Yes ☐ No
How much stress would you say you are under right now?	☐ More than usual ☐ Less than usual ☐ the same	
Is your stress related to: (Please check all that apply)	☐ Work ☐ Personal ☐ Other	
Have you felt:	☐ Hopeless ☐ Helpless ☐ Worthless ☐ Useless	
How is your appetite?:	☐ Worse than usual ☐ Better than usual ☐ the same	
Have you had any suicidal thoughts lately?		☐ Yes ☐ No
In response to intense emotion (laughter, anger, surprise) have you felt sudden muscle weakness in your legs, neck or other extremities?		☐ Yes ☐ No
Please explain:		
Before you are fully asleep, do you have vivid, sometimes frightening dream like hallucinations?		☐ Yes ☐ No
Please explain:		
Have you ever wakened from sleep and felt like your body was "paralyzed" and you could not move even though you could see and breathe?		☐ Yes ☐ No
Do you ever have difficulty falling asleep do to pain, cramping, twitching or a crawling sensation in your legs?		☐ Yes ☐ No

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UNIVERSAL MEDICATION FORM

Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	
Physicians providing care at this time:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name