

# SLEEP CONSULTATION & MEDICAL HISTORY

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

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	

## CHIEF COMPLAINTS IN WHICH YOU ARE SEEKING TREATMENT

<input type="checkbox"/> Y <input type="checkbox"/> N	DIFFICULTY SWALLOWING	<input type="checkbox"/> Y <input type="checkbox"/> N	RINGING IN EARS
<input type="checkbox"/> Y <input type="checkbox"/> N	DIZZINESS	<input type="checkbox"/> Y <input type="checkbox"/> N	CPAP INTOLERANCE
<input type="checkbox"/> Y <input type="checkbox"/> N	HEADACHES	<input type="checkbox"/> Y <input type="checkbox"/> N	DIFFICULTY FALLING ASLEEP
<input type="checkbox"/> Y <input type="checkbox"/> N	JAW CLICKING/POPPING	<input type="checkbox"/> Y <input type="checkbox"/> N	DIFFICULTY MAINTAINING SLEEP
<input type="checkbox"/> Y <input type="checkbox"/> N	JAW LOCKING	<input type="checkbox"/> Y <input type="checkbox"/> N	FATIGUE
<input type="checkbox"/> Y <input type="checkbox"/> N	JAW PAIN	<input type="checkbox"/> Y <input type="checkbox"/> N	FREQUENT HEAVY SNORING
<input type="checkbox"/> Y <input type="checkbox"/> N	LIMITED MOUTH OPENING	<input type="checkbox"/> Y <input type="checkbox"/> N	GASPING UPON WAKENING
<input type="checkbox"/> Y <input type="checkbox"/> N	NECK PAIN	<input type="checkbox"/> Y <input type="checkbox"/> N	NIGHTTIME CHOKING SPELLS
<input type="checkbox"/> Y <input type="checkbox"/> N	MORNING HEADACHES	<input type="checkbox"/> Y <input type="checkbox"/> N	DAYTIME DROWSINESS
<input type="checkbox"/> Y <input type="checkbox"/> N	PAIN UPON CHEWING	<input type="checkbox"/> Y <input type="checkbox"/> N	SLEEPY WHILE DRIVING
<input type="checkbox"/> Y <input type="checkbox"/> N	NOCTURNAL TEETH GRINDING/CLENCHING	<input type="checkbox"/> Y <input type="checkbox"/> N	WITNESSED APNEIC EVENTS
<input type="checkbox"/> Y <input type="checkbox"/> N	WAKING UNREFRESHED IN AM	<input type="checkbox"/> OTHER	

Surgeries (Please Print Clearly)		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

## SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you interested in a diet program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea
	<input type="checkbox"/> Cola		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
	<input type="checkbox"/> Cigars - #/day		

## FAMILY HEALTH HISTORY

<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma/COPD	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid trouble
<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Mother snores
<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Father snores
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Mother has sleep apnea
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Father has sleep apnea
<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Obesity
<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Other	

## HEALTH HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> NERVOUSNESS
<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CHRONIC FATIGUE	<input type="checkbox"/> FIBROMYALGIA
<input type="checkbox"/> TONSILS/ADENOIDS REMOVED	<input type="checkbox"/> CHRONIC PAIN	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> DIABETES
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> DIFFICULTY CONCENTRATING
<input type="checkbox"/> ASTHMA/COPD	<input type="checkbox"/> LUNG DISEASE	<input type="checkbox"/> EPILEPSY
<input type="checkbox"/> AUTO IMMUNE DISORDER	<input type="checkbox"/> MENOPAUSAL PROBLEMS	<input type="checkbox"/> FREQUENT URINATION
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> MULTIPLE SCLEROSIS	<input type="checkbox"/> GALL BLADDER PROBLEMS
<input type="checkbox"/> HEARTBURN	<input type="checkbox"/> MUSCULAR DYSTROPHY	<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> PACEMAKER

<input type="checkbox"/> HEART PALPITATIONS	<input type="checkbox"/> HEART VALVE REPLACEMENT	<input type="checkbox"/> HEPATITIS (A,B,C)
<input type="checkbox"/> HORMONE PROBLEMS	<input type="checkbox"/> INFECTIOUS MONONUCLEOSIS	<input type="checkbox"/> INSOMNIA
<input type="checkbox"/> INTESTINAL DISORDERS	<input type="checkbox"/> POOR DIGESTION	<input type="checkbox"/> POLIO
<input type="checkbox"/> PARKINSONS DISEASE	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> POOR CIRCULATION
<input type="checkbox"/> PSYCHIATRIC CARE	<input type="checkbox"/> RADIATION TREATMENT	<input type="checkbox"/> REDUCED SEX DRIVE
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> SCARLET FEVER	<input type="checkbox"/> SCOLIOSIS
<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> SKIN DISORDER
<input type="checkbox"/> SLEEP APNEA	<input type="checkbox"/> STROKE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> TUMORS	<input type="checkbox"/> MEMORY LOSS	<input type="checkbox"/> EMOTIONAL UPSETS

## THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
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 (i.e. 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	_____

Signature: \_\_\_\_\_ Date: \_\_/\_\_/20\_\_