FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Sleep Center Health History Questionnaire

Name _____ **Date of Birth** _____

Local Pharmacy: _____ **Phone**: ( ) _____-_____

Location: _____ **City** _____ **State:** _____

Personal Health History		
Please check if you have had any of the following		
☐ Anemia	☐ Hay fever	☐ Phlebitis/blood clots
☐ Arthritis	☐ Heart attack/angina	☐ Prostate problems
☐ Asthma	☐ Heart disease	☐ Rashes
☐ Bone fractures	☐ Heart murmur	☐ Rheumatic fever
☐ Bronchitis	☐ Heart valve disease	☐ Seizures
☐ Cancer	☐ High blood pressure	☐ Sinusitis
☐ Depression	☐ Irregular heartbeat	☐ Sleep problems
☐ Diabetes	☐ Kidney stones	☐ Stroke/TIA
☐ Emphysema	☐ Nervousness	☐ Thyroid problems
☐ Gastric reflux	☐ Osteoporosis	☐ Ulcers
☐ Gout	☐ Pneumonia	☐ Urine infections

Allergies	
Please list any allergies to medications or foods	
Name	Symptom/Reaction

Health Maintenance

Please check whether you have had the following preventative services and enter the month and year of the service

Immunizations	Last Occurrence Month	Last Occurrence Year		Tests	Last Occurrence Month	Last Occurrence Year
Influenza vaccine				TB Skin Test		
Pneumonia vaccine						

Family History

Relative	Age	Alive (Y/N)	Medical Problems	Cause of Death
Father				
Mother				
Sibling				
Sibling				
Child				
Child				

Social History				
Place of Birth?				
Marital status: ☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated
Occupation:				

Medical Problems

Surgical History		
Month	Year	Procedure

Recently Hospitalizations		
Date	Hospital	Reason for admission

Sleep Center Survey
Are you wheelchair bound? ☐ Yes ☐ No
Are you able to transport yourself to the bed and the restroom? ☐ Yes ☐ No
If no, will you be able to provide a caretaker or relative to assist you? ☐ Yes ☐ No

Are there any special accommodations that you require? Please explain.

Are you on continuous oxygen? ☐ Yes ☐ No
Are you able to take medications on your own? ☐ Yes ☐ No
If no, will you be able to provide a caretaker or relative to assist you? ☐ Yes ☐ No
Do you have memory problems, dementia or sundowning? ☐ Yes ☐ No

Are there any special accommodations that you require? Please explain.

Provide information on any medical issues you would like our team to know about.

How did you first hear about our sleep center?		
☐ Physician	☐ Relative	☐ Friend
☐ Seminar	☐ Sleep Society	☐ Newspaper/Journal/Magazine/T.V.
☐ Radio	☐ Other:	

Describe your main problem(s) in your own words, including when and how it began and what treatment you have received for this in the past.			
How often does this problem occur?			
☐ Almost every night	☐ For periods of at least one week	☐ Irregularly	☐ Other
How long has this problem bothered you?			
☐ Longer than 2 years	☐ 1 to 2 years	☐ Several months	
☐ Within the last 3 months	☐ Within the last month		
Estimate the severity of your problem.			
☐ Mildly upsetting	☐ Moderately upsetting	☐ Very severe	
☐ Extremely severe	☐ Totally incapacitating		
How strongly do you want help with your sleep problems?			
☐ Very much	☐ Much	☐ Moderately	☐ Could do without
How do you describe your sleep problem?			
☐ Difficulty falling asleep	☐ Wake up during the night	☐ Wake up early in the morning	
☐ Excessive daytime sleepiness	☐ Difficulty awakening		
Do any other members of your family have sleep problems? Please explain.			
Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?			
☐ General Practitioner ☐ Other Physician ☐ Other Internist ☐ Obstetrics/Gynecology ☐ Clinical Psychologist ☐ Social Worker ☐ Cardiologist ☐ Chiropractor ☐ Psychiatrist ☐ Counselor ☐ Nutritionist ☐ Clergyman ☐ Nurse ☐ Osteopath ☐ Other:_____			
What treatments have you received?			

Please rate how often you experience the following.					
Problem	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Awaken from sleep short of breath					
Awaken at night with heartburn, belching, or cough					
Snore					
Snore so loudly that others complain					
Have trouble sleeping when you have a cold					
Suddenly wake up gasping for breath during the night					
Have breathing problems at night					
Fall asleep during the day					
Fall asleep involuntarily					
Fall asleep driving					
Fall asleep during physical effort					
Fall asleep when laughing or crying					
Experience loss of muscle tone when extremely emotional					
Have trouble at work or school because of sleepiness					

Problem	Never	Rarely	Sometimes	Frequently	Constantly
Feel unable to move (paralyzed) when waking or falling asleep					
Experience vivid dream-like scenes upon awakening or falling asleep					
Feel afraid of going to sleep					
Have nightmares					
Remember your dreams					
Have thoughts racing through your mind					
Feel sad and depressed					
Have anxiety (worry about things)					
Have muscular tension					
Notice parts of your body jerk					
Experience crawling and aching feelings in your legs					
Experience any type of leg pain during the night					
Have morning jaw pain					
Grind teeth during sleep					
Are bothered by pain during the day					
Are awakened by pain during the night					
Wake up feeling stiff in the morning					
Wake up with sore or achy muscles					
Wake up with pain in neck, spine or joints					

Is your present work situation satisfactory? Please explain.

Please select any of the following that apply to you.

☐ Headaches	☐ Palpitations	☐ Bowel disturbances
☐ Nightmares	☐ Feel tense	☐ Depressed
☐ Unable to relax	☐ Don’t like weekends and vacations	☐ Can't keep a job
☐ Financial problems	☐ No appetite	☐ Alcoholism
☐ Take drugs	☐ Can't make decisions	☐ Unable to have a good time
☐ Take antacids regularly	☐ Dizziness	☐ Stomach trouble
☐ Fatigue	☐ Take sedatives	☐ Feel panicky
☐ Suicidal thoughts	☐ Sexual problems	☐ Overambitious
☐ Memory problems	☐ Inferiority feelings	☐ Fainting spells
☐ Insomnia	☐ Tremors	☐ Shy with people
☐ Home conditions bad	☐ Concentration difficulties	☐ Other:

Does your sleep problem disturb your sex life?
(Provide any information about significant relationships.)

Select any of the following words or phrases that apply to you.				
☐ Worthless	☐ Useless	☐ A "nobody"	☐ "Life is empty"	☐ Lonely
☐ Stupid	☐ Incompetent	☐ Naïve	☐ "Can't do anything right"	☐ Guilty
☐ Full of hate	☐ Morally wrong	☐ Horrible thoughts	☐ Hostile	☐ Evil
☐ Anxious	☐ Agitated	☐ Cowardly	☐ Unassertive	☐ Panicky
☐ Aggressive	☐ Ugly	☐ Deformed	☐ Inadequate	☐ Unloved
☐ Misunderstood	☐ Unconfident	☐ Restless	☐ Confused	☐ Bored
☐ In conflict	☐ Full of regrets	☐ Worthwhile	☐ Sympathetic	☐ Intelligent
☐ Attractive	☐ Confident	☐ Considerate	☐ Other:	

Is your present social life satisfactory? Does your sleep problem require you to cut back on social activities? If so, how?

Provide answers to the following questions.	
How many hours do you usually sleep per night?	
What time do you usually go to bed on weekdays?	
What time do you usually go to bed on weekends?	
How long does it take you to fall asleep?	
How many times do you typically wake up at night?	
If you wake up, on average how long do you stay awake?	

If you awaken during the night (after you first fell asleep) which part(s) of your sleep period is it?		
☐ Soon after falling asleep	☐ Middle of the night	☐ Early morning

What do you usually do when you awaken during the night?

What time do you usually awaken in the morning on weekdays?	
What time do you usually awaken in the morning on weekends?	

Do you usually:		
☐ Sleep with someone else in your bed	☐ Sleep with someone else in your room	☐ Provide assistance to someone during the night (ex. child, invalid, bed partner, animal)

Is your sleep often disturbed by:						
☐ Heat	☐ Cold	☐ Noise	☐ Light	☐ Bed partner	☐ Not being in your usual bed	☐ Other:

Are your sleep habits on weekends different from the rest of the week? If yes, please describe.

With whom are you living with now (ex. spouse, children, parents, etc.)?	Age

Do you work split shifts or have rotating (variable) shifts?		☐ Yes	☐ No
Do you feel better during:	☐ Morning	☐ Afternoon	☐ Evening

Answer 'Yes' or 'No' to the following questions.		
Situation	**Yes**	**No**
Do you usually drink coffee or tea within two hours of going to bed?		
Do you perform physical exercise before going to bed?		
Do you read before falling asleep?		
Do you take naps during the afternoon or evening?		
Do you feel refreshed after a short (10-15 min) nap?		
Do you feel rested after an average night of sleep?		

Medications

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Frequency

List your consumption of the following per day.		
Substance	**Amount consumed per day**	
Coffee		
Colas		
Teas		
Nicotine		
Alcohol		
Chocolate		
Over the counter medications		
Other:		
Have you had a car accident or near-miss crash associated with drowsiness/excessive sleepiness?	☐ Yes	☐ No

What is your personal interpretation as to why you have your particular sleep/wake problems?

Please describe any other information pertinent to your sleep/wakefulness problem not previously described.

Patient/Guardian Signature: _____ Date: _____

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Scanning Category: Health History Questionnaire/Sleep Center