SOMNIQUE HEALTH

Adult Sleep Questionnaire

DATE:_____

Name _____ D.O.B. _____/_____/_____

Age _____ Sex _____ Height _____ Weight _____

SLEEP HISTORY

Briefly describe the problem you are having with your sleep:

_____

_____

_____

Please check if you currently have or have had any of the following:

_____ Has anyone said you snore loudly

_____ Do you snore in all positions

_____ Has anyone said you stop breathing at night

_____ Wake up gasping for breath

_____ Wake up coughing or choking

_____ Wake up with headaches

_____ Wake up with a sore throat

_____ Wake up with chest tightness or discomfort

_____ Wake up because of your bed partner (noise or movement)

_____ Sleep better when you are away from your own bed (vacation or visiting family)

_____ Provide assistance at night to another person at night (elderly or infant)

_____ Sleep problems as a child

_____ Sleep walk

_____ Sleep talk

_____ Wake up screaming

_____ Frequent nightmares

_____ Grind your teeth in your sleep

_____ Eating while asleep

_____ Difficulty initiating sleep at night

_____ Difficulty maintaining sleep at night

_____ Restless sleep

_____ Pain that prevents you from sleeping soundly

_____ Kick or thrash around at night

_____ Excessive sleepiness as a teenager or young adult

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SLEEP HISTORY, CONTINUED

_____ Excessive daytime sleepiness

_____ Excessive daytime fatigue

_____ Uncomfortable or unpleasant sensation in your legs during periods of rest or when you are lying down or sitting

_____ Urge to move (walking and stretching) in order to relieve an uncomfortable or unpleasant sensation in your legs

_____ If you checked the above, does the relief only last as long as you continue to walk or stretch?

_____ If you checked the above, do the uncomfortable or unpleasant sensations only occur at night?

_____ Do you fall asleep while driving?

_____ Do you feel like you must take a nap during the day?

_____ Have you had an auto accident in the last five years?

_____ Difficulty concentrating.

_____ Wake up with a sour taste in your mouth

_____ Sleepy even when you increase sleep time

_____ Sudden episodes of sleep during the day

_____ Feel paralyzed while going to sleep or waking up

_____ Sudden physical weakness during strong emotions (such as your mouth dropping open or legs going limp during laughter or anger)

_____ Vivid hallucinations or dream-like images when falling to sleep

_____ Have you had an accident at work due to sleepiness?

_____ Sleepy even when on vacation

SLEEP SCHEDULE

	Weekday	**Weekend**
What time do you go to bed?	_____ AM/PM	_____ AM/PM
What time do you wake up?	_____ AM/PM	_____ AM/PM
Average amount of sleep per night:	_____ Hours	_____ Hours
Do you have a rotating schedule or night shift work?	_____ Yes	_____ No

How long does it take you to go to sleep? _____

How do you feel when you wake up? _____

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PAST MEDICAL HISTORY

Have you had any surgeries? If yes, what year?
_____ Ear nose or throat surgery _____
_____Appendectomy_____
_____ Gall bladder surgery _____
_____ Cardiac bypass _____
_____Other _____

Please check if you have any history of the following medical problems.
_____ High blood pressure _____ Heart disease _____ Lung disease
_____ Urine incontinence _____ Diabetes _____ Arthritis _____ Seizure disorder
_____ Other (please explain)_____

CURRENT MEDICATIONS

Medication list (please list the name of each medication)

_____ _____ _____

_____ _____ _____

Over the counter medications / herbal supplements: _____

Do you have any allergies? _____ Yes _____ No If yes, please list: _____

SOCIAL HISTORY/HABITS

Please check and answer all of the following:

Are you currently employed? _____ Yes _____ No Current job title _____

Marital status _____ Married _____ Single

Are you a Current Smoker? _____ Yes _____ No Are you a Former Smoker? _____ Yes _____ No

If yes, how long?_____ How many packs per day?_____

Do you drink alcohol? _____ Yes _____ No If yes, how often? _____

Do you drink coffee, tea, or soft drinks? _____ Yes _____ No
If yes, regular_____ or decaffeinated _____ How much daily? _____

Have you used marijuana, cocaine or other drugs in the past 12 months? _____ Yes _____ No

If yes, which drug and how often? _____

How many meals do you eat daily? 0 1 2 3 4 5 Do you exercise regularly? _____Yes _____ No

If yes, how many times per week? _____ What time of the day? Morning Mid-day Evening

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IMMEDIATE FAMILY (mother, father, siblings)

List each person with disorder:

Diabetes _____ Snoring _____
Heart disease _____ Sleep Apnea _____
High blood pressure _____ Narcolepsy _____
Stroke _____ Daytime sleepiness _____
Obesity _____ Other _____

SYSTEMS REVIEW

Please check if you currently have or have had any of the following:

Constitutional
_____ Fever _____ Weight gain _____lbs. _____ Weight loss_____lbs. _____ Fatigue
_____ Night sweats

Eyes
_____ Pain _____ Redness _____ Loss of vision _____ Double or blurred vision _____ Dryness

Ears-Nose-Mouth-Throat
_____ Hearing loss _____ Nosebleeds _____ Loss of smell _____ Dryness in nose _____ Loss of taste _____ Sores in mouth _____ Dryness of mouth _____ Hoarseness

Cardiovascular
_____ Chest Pain _____ Irregular heart beat _____ High blood pressure _____ Swollen legs or feet

Respiratory
_____ Shortness of breath _____ Difficulty breathing at night _____ Cough _____ Coughing up blood
_____ Wheezing

Gastrointestinal
_____ Loss of appetite _____ Nausea _____ Vomiting of blood or "coffee ground" material
_____ Abdominal pain _____ Heartburn/reflux _____ Difficulty swallowing _____ Diarrhea
_____ Constipation _____ Blood in stools _____ Black stool

Urinary
_____ Difficult urination _____ Pain or burning on urination _____ Blood in urine
_____ Vaginal dryness _____ Discharge from penis/vagina _____ Rash/ulcers

Musculoskeletal
_____ Morning stiffness _____ Joint pain or swelling _____ Muscle weakness _____ Muscle tenderness

Skin
_____ Easy bruising _____ Rashes _____ Sun sensitivity _____ Tightness _____ Nodules/bumps
_____ Hair loss

Neurological
_____ Headaches _____ Dizziness _____ Weakness _____ Memory loss

Psychiatric
_____ Excessive worries _____ Anxiety _____ Easily loses temper _____ Depression _____ Agitation

Endocrine _____ Excessive thirst

Hematologic
_____ Swollen glands _____ Tender glands _____ Bleeding tendency _____ Anemia _____ Transfusion

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Is there any other information you would like us to know that was not covered in this questionnaire?

_____

_____

How did you choose Somnique Sleep Health? Check and explain all that apply.

_____ Physician _____

_____ On-line _____

_____ Friend _____

_____ Newspaper _____

_____ Radio _____

_____ Other _____

Thank you for your time in filling this questionnaire out. It is a valuable tool for the physician.

Please bring this with you to your first appointment. We look forward to meeting you!