

16. What position (s) do you sleep in?
 Back left side right side stomach chair hospital bed
17. Do you take naps during the day?
 a. Never 1-2 times weekly 3-4 times weekly 5-6 times weekly Everyday
 b. How long do you nap? _____
 c. Do you wake up from your naps refreshed? Yes No Somewhat
18. Do you snore loud enough to wake yourself or disturb others?
 Never Rarely Occasionally Frequently
19. Has anyone told you that you hold your breath or stop breathing while you sleep? Yes No
 Explain: _____
20. Do you wake up with a choking feeling at night? Never Rarely Occasionally Frequently
21. Do you wake up with heartburn or acid reflux? Never Rarely Occasionally Frequently
22. Do you wake up in the morning with a headache?
 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday
23. Do you get up to urinate at night? Yes No How often? _____
24. Do you tend to sweat heavily at night? Never Rarely Often
25. Are you a restless sleeper? Yes No
 (e.g. change positions a lot, toss and turn, wake up with bed sheets and blankets out of place)?
26. Do you frequently wake up with a dry mouth? Yes No
27. Do you grind your teeth or clench at night? Grind Clench Neither
28. Do you experience muscle cramps in your legs at night?
 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday
29. Have you been told or noticed that your arms or legs jump or twitch frequently when you sleep?
 Never Rarely Occasionally Frequently
30. When you try to relax in the evening or at bedtime, do you ever have unpleasant, restless feelings in your legs or arms (other than muscle cramps) that can be relieved by movement (e.g. stretching legs, massaging legs, pounding legs, getting up and walking)?
 Never 1-3 times per/month 1-3 times/week 4-6 times/week Everyday
 Describe the feeling: _____
 How old were you when the unpleasant restless leg/arm feelings started? _____
31. Do you sleepwalk now or have you in the past five years? Yes No
 Provide details if yes. _____
32. Have you ever had a seizure (convulsion, epilepsy) while sleeping? Yes No
 If yes, when? _____
33. Do you fall asleep unintentionally during the day? (e.g. work, meeting, school, reading, TV)
 Never Rarely Occasionally Frequently
 Explain: _____

34. Do you frequently get sleepy or drowsy while driving? Yes No
35. Do you have difficulty with: a. short term memory b. focus/concentration
36. Do you worry or experience anxiety about your sleep? Never Infrequently Frequently
37. How often do you dream? Never Occasionally Frequently
38. Have you ever woken up feeling like you were acting out a dream? Yes No
39. Have you ever woken up feeling like your muscles were paralyzed and you couldn't move?
 Yes No
40. Have you ever felt like you:
- a. started to dream before falling asleep Yes No
- b. were still dreaming after you woke up Yes No
41. Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following situations?
- a. When you laugh Yes No
- b. When you are angry Yes No
- c. When hearing or telling a joke Yes No
42. Have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during any of the following situations?
- a. When tense or under stress Yes No
- b. During or after exercise Yes No
- c. Other (if YES please specify) Yes No
43. How likely are you to doze or fall asleep in the situations described below, in contrast to just feeling 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 = would never doze 1 = slight chance of dozing	2 = moderate chance of dozing 3 = high chance of dozing																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 5px;">Situation</th> <th colspan="4" style="text-align: center; padding: 5px;">Chance of dozing (circle a #)</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Sitting and reading</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">Watching TV</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">Sitting, inactive in a public place (e.g. a theater or a meeting)</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">As a passenger in a car for an hour without a break</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">Lying down to rest in the afternoon when circumstances permit</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">Sitting and talking to someone</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">Sitting quietly after a lunch without alcohol</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="padding: 5px;">In a car, while stopped for a few minutes in traffic</td> <td style="text-align: center; padding: 5px;">0</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">3</td> </tr> </tbody> </table>		Situation	Chance of dozing (circle a #)				Sitting and reading	0	1	2	3	Watching TV	0	1	2	3	Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3	As a passenger in a car for an hour without a break	0	1	2	3	Lying down to rest in the afternoon when circumstances permit	0	1	2	3	Sitting and talking to someone	0	1	2	3	Sitting quietly after a lunch without alcohol	0	1	2	3	In a car, while stopped for a few minutes in traffic	0	1	2	3
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 Community Hospital of the Monterey Peninsula®

SLEEP DISORDERS QUESTIONNAIRE

44. Check or list all childhood diseases you recall having:

whooping cough chicken pox measles
 rheumatic fever mumps German measles
 polio
 Other: _____

45. Check any of these medical problems you have now or in the past:

sleep apnea restless legs syndrome narcolepsy
 depression anxiety disorder bipolar disorder
 schizophrenia TMJ disorder dentures
 migraine headaches seizure/epilepsy
 GERD/acid reflux prostate enlargement
 hypertension (blood pressure) diabetes (blood sugar)
 cholesterol/triglyceride/lipid disorder
 atrial fibrillation abnormal heart rhythm heart attack
 congestive heart failure cardiomyopathy stroke *or* TIA
 iron deficiency anemia
 AIDS/HIV infection Alcohol abuse Drug abuse

46. Check or list any of these medical problems you have now or in the past:

asthma Nose/Sinus allergy (pollen, plants, animals, dust etc)
 eczema Positive allergy testing: _____
 allergy shots: When & What type? _____
 COPD (e.g. chronic bronchitis, bronchiectasis, emphysema, cystic fibrosis)
 pulmonary fibrosis asbestos lung disease sarcoidosis
 tuberculosis valley fever (cocci)
 DVT (blood clot in leg) pulmonary embolism (blood clot in lung)
 pulmonary hypertension
 Other lung disease (explain): _____

47. Check or list any of these medical problems you have now or in the past:

stomach ulcer ulcerative colitis or Crohn's diverticulitis
 yellow jaundice gallstones pancreatitis
 hepatitis or other liver disease (provide details) _____
 osteoarthritis gout lupus
 rheumatoid arthritis other arthritis scleroderma
 kidney stones other kidney disease _____
 thyroid disorder (explain): _____
 Cataracts glaucoma macular degeneration

Cancer/malignancy (Check all that apply)			
<input type="checkbox"/> Lung	<input type="checkbox"/> Prostate	<input type="checkbox"/> Liver	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Colon	<input type="checkbox"/> Bladder	<input type="checkbox"/> Brain	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Breast	<input type="checkbox"/> Kidney	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Melanoma



SLEEP DISORDERS QUESTIONNAIRE

48. Other major medical problems: _____

49. TB skin test:

PPD (TB Skin test)	<input type="checkbox"/> never done	year:	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
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50. Check or list all surgery you remember having:

<input type="checkbox"/> tonsils removed	<input type="checkbox"/> adenoids removed	<input type="checkbox"/> Sinus surgery
<input type="checkbox"/> nasal septum repaired	<input type="checkbox"/> soft palate/uvula removed	<input type="checkbox"/> tongue surgery
<input type="checkbox"/> jaw surgery	<input type="checkbox"/> heart bypass	<input type="checkbox"/> heart valve replaced
<input type="checkbox"/> heart stent or angioplasty	<input type="checkbox"/> other stent or angioplasty	<input type="checkbox"/> pacemaker or defibrillator
<input type="checkbox"/> gallbladder removed	<input type="checkbox"/> lung surgery	<input type="checkbox"/> ulcer surgery
<input type="checkbox"/> hiatal hernia surgery	<input type="checkbox"/> appendix removed	<input type="checkbox"/> hysterectomy
<input type="checkbox"/> hip replacement surgery	<input type="checkbox"/> knee replacement	<input type="checkbox"/> prostate surgery
<input type="checkbox"/> cataract surgery	<input type="checkbox"/> retinal surgery	

Other surgery and year: _____

51. List all prescription medications you take including asthma inhalers, nasal sprays, topical medications and as needed medications (OR ATTACH A LIST OF YOUR MEDICATIONS):

Medicine	Dose or strength	When & how often you take it
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		



SLEEP DISORDERS QUESTIONNAIRE

52. List all over-the-counter medicine you take, including vitamins, minerals, supplements, herbals

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

53. When and where did you get your last vaccines:

Vaccine	Date	Where received
Flu (influenza) vaccine		
Pneumovax (pneumonia vaccine)		
Pertussis (whooping cough vaccine)		
Hepatitis vaccine		
Varicella vaccine (shingles, chicken pox)		
Tetanus vaccine		
Other adult vaccine (list):		

54. List any medications you are sensitive to , allergic to or react badly to:

Name of Medicine	Type of reaction (e.g. hives, breathing problem)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

55. Have you had an x-ray test where dye (contrast) was injected into your vein or artery?

Yes No

If yes, describe any side effects or allergic reaction to the dye: _____

56. Have you ever received chemotherapy or radiation therapy? Yes No

When? _____ Why? _____

57. Have you ever donated blood? Yes No When? _____

58. Have you ever received a blood transfusion? Yes No When? _____

59. Do you think you might be at risk for HIV infection or AIDS? Yes No



SLEEP DISORDERS QUESTIONNAIRE

60. Are you: married never married widowed separated divorced
61. Who lives at home with you? _____
62. a. Where did you grow up? _____
b. Where else have you lived and when? _____
c. How long have you lived locally? _____
63. What is your highest level of school attended? _____
64. Are you currently? self-employed employee unemployed
 disabled retired other _____
65. What is your current or most recent occupation? _____
66. What other type of work have you done in the past? _____

67. Describe any military experience? _____
68. List travel outside the United States in the past 5 years _____
69. Describe your diet: _____
70. Describe your usual exercise: _____
71. Do you currently smoke: cigarettes cigars pipe marijuana
How much do you smoke? _____
72. If you don't smoke currently, describe your past smoking habits: *how much & how long?*
 never smoked _____
73. Do you drink Beer How much per day? _____ per week? _____
Do you drink Wine How much per day? _____ per week? _____
Do you drink Hard Liquor How much per day? _____ per week? _____
74. If you don't drink alcohol currently, describe past alcohol consumption: *how much & how long?*
 never drank alcohol _____
75. Do you drink any caffeinated beverages?
 coffee How much? _____
 tea How much? _____
 cola/mountain dew How much? _____
 energy drinks How much? _____
76. List any pets at home, including birds, rodents, reptiles e.t.c.

77. What hazardous materials, fumes, dusts, chemicals etc. have you been exposed to?
 exotic birds or bird feathers grain dust moldy hay
 hot tub/spa at home asbestos beryllium
 sandblasting welding heavy metals
 pesticides solder baking flour dust
 other (explain) _____

78. List family members with the following problems:

<input type="checkbox"/> sleep apnea	<input type="checkbox"/> loud snoring	<input type="checkbox"/> restless leg syndrome
<input type="checkbox"/> narcolepsy		<input type="checkbox"/> long-term insomnia
<input type="checkbox"/> depression		<input type="checkbox"/> anxiety disorder
<input type="checkbox"/> high blood pressure		<input type="checkbox"/> diabetes
<input type="checkbox"/> high cholesterol or triglycerides		<input type="checkbox"/> heart attack or clogged arteries
<input type="checkbox"/> congestive heart failure		<input type="checkbox"/> stroke
<input type="checkbox"/> pulmonary hypertension		<input type="checkbox"/> pulmonary fibrosis
<input type="checkbox"/> asthma		<input type="checkbox"/> allergies, e.g. pollen, dust, cat allergy
<input type="checkbox"/> blood clot problems		<input type="checkbox"/> bleeding disorder
<input type="checkbox"/> dementia or Alzheimers		<input type="checkbox"/> Parkinson's

79. Complete the following about your family medical history:

I am adopted and don't know anything about my biological family medical problems

Relative	Age	Alive	Cause of death	Major health problems
Father		<input type="checkbox"/> yes <input type="checkbox"/> no		
Mother		<input type="checkbox"/> yes <input type="checkbox"/> no		

Complete this table for brothers, sisters, sons, daughters - please list them even if healthy

Relative	Age	Alive	Cause of death	Major health problems
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		
		<input type="checkbox"/> yes <input type="checkbox"/> no		

80. Review of Systems

How tall are you? _____

Have you lost height due to osteoporosis or other reasons? Yes No

If so, how much height have you lost from your tallest? _____

What is your neck size (if known)? _____

What is your most recent weight? _____

How much did you weigh 1 year ago? _____

How much did you weigh 5 years ago? _____

How much did you weigh 10 years ago? _____

How much did you weigh at age 21? _____

Are you *currently experiencing*

Yes	No	Constitutional	Yes	No	Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	chest pain or pressure
<input type="checkbox"/>	<input type="checkbox"/>	weight loss	<input type="checkbox"/>	<input type="checkbox"/>	palpitations
<input type="checkbox"/>	<input type="checkbox"/>	weight gain	<input type="checkbox"/>	<input type="checkbox"/>	rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	chills or fevers	<input type="checkbox"/>	<input type="checkbox"/>	slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	heavy sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	fatigued/tired			
Yes	No	Eye	Yes	No	Respiratory
<input type="checkbox"/>	<input type="checkbox"/>	blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	cough
<input type="checkbox"/>	<input type="checkbox"/>	loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	sputum production
<input type="checkbox"/>	<input type="checkbox"/>	itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	coughing up blood
<input type="checkbox"/>	<input type="checkbox"/>	watery eyes			trouble breathing
<input type="checkbox"/>	<input type="checkbox"/>	dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	with exertion
<input type="checkbox"/>	<input type="checkbox"/>	eye pain	<input type="checkbox"/>	<input type="checkbox"/>	trouble breathing
			<input type="checkbox"/>	<input type="checkbox"/>	laying down
					waking up at night
Yes	No	ENT	<input type="checkbox"/>	<input type="checkbox"/>	with difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	wheezing
<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	chest tightness
<input type="checkbox"/>	<input type="checkbox"/>	impaired smell	Yes	No	Gastrointestinal
<input type="checkbox"/>	<input type="checkbox"/>	impaired taste	<input type="checkbox"/>	<input type="checkbox"/>	nausea or vomiting
<input type="checkbox"/>	<input type="checkbox"/>	frequent bad breath	<input type="checkbox"/>	<input type="checkbox"/>	difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	recurring nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	pain when swallowing
<input type="checkbox"/>	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	<input type="checkbox"/>	belly pain
<input type="checkbox"/>	<input type="checkbox"/>	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	heart burn
<input type="checkbox"/>	<input type="checkbox"/>	nasal decongestant spray (e.g. Afrin, 4-way)	<input type="checkbox"/>	<input type="checkbox"/>	acid reflux
<input type="checkbox"/>	<input type="checkbox"/>	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	frequently clear throat	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	dark black stools
<input type="checkbox"/>	<input type="checkbox"/>	sore throat			

Are you *currently experiencing*

Yes	No	Constitutional
<input type="checkbox"/>	<input type="checkbox"/>	muscle pain Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	leg cramps at night
<input type="checkbox"/>	<input type="checkbox"/>	joint pain Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	joint stiffness Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	joint swelling Where? _____

Yes	No	Integument
<input type="checkbox"/>	<input type="checkbox"/>	current skin rash
<input type="checkbox"/>	<input type="checkbox"/>	frequent itching
<input type="checkbox"/>	<input type="checkbox"/>	current skin cancer
<input type="checkbox"/>	<input type="checkbox"/>	other skin problem

Explain: _____

Yes	No	Neurologic
<input type="checkbox"/>	<input type="checkbox"/>	frequent headaches
<input type="checkbox"/>	<input type="checkbox"/>	recent seizure
<input type="checkbox"/>	<input type="checkbox"/>	recent stroke
<input type="checkbox"/>	<input type="checkbox"/>	difficulty walking
<input type="checkbox"/>	<input type="checkbox"/>	difficulty speaking
<input type="checkbox"/>	<input type="checkbox"/>	memory loss
<input type="checkbox"/>	<input type="checkbox"/>	hand tremor
<input type="checkbox"/>	<input type="checkbox"/>	sensation of room spinning

Yes	No	Psychiatric
<input type="checkbox"/>	<input type="checkbox"/>	depression
<input type="checkbox"/>	<input type="checkbox"/>	anxiety or nervousness
<input type="checkbox"/>	<input type="checkbox"/>	hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	paranoid thoughts
<input type="checkbox"/>	<input type="checkbox"/>	claustrophobia

Yes	No	Endocrine
<input type="checkbox"/>	<input type="checkbox"/>	poor tolerance of cold
<input type="checkbox"/>	<input type="checkbox"/>	poor tolerance of heat
<input type="checkbox"/>	<input type="checkbox"/>	extreme thirst
<input type="checkbox"/>	<input type="checkbox"/>	loss of interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	poor sexual function

Yes	No	Heme & Lymphatic
<input type="checkbox"/>	<input type="checkbox"/>	anemia: Why? _____
<input type="checkbox"/>	<input type="checkbox"/>	iron deficiency
<input type="checkbox"/>	<input type="checkbox"/>	swollen glands: Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	easy bleeding
<input type="checkbox"/>	<input type="checkbox"/>	easy bruising

Yes	No	Allergic & Immunologic
<input type="checkbox"/>	<input type="checkbox"/>	immune problem: Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	serious or life-threatening allergy Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	autoimmune disorder Explain: _____

Yes	No	Genitourinary system
<input type="checkbox"/>	<input type="checkbox"/>	difficult - slow urination
<input type="checkbox"/>	<input type="checkbox"/>	pain when urinating
<input type="checkbox"/>	<input type="checkbox"/>	blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	urinate at night? How often? _____
<input type="checkbox"/>	<input type="checkbox"/>	poor bladder control

Female reproductive
 How many pregnancies? _____
 How many miscarriages? _____
 Are you still menstruating? _____
 Unusually prolonged or heavy bleeding?
 yes no

Durable power of attorney for health care

If you are unable to make your own medical decisions, who should we contact as a representative to speak for you?
Name: _____
Relationship: _____
Phone: _____
Alternate: _____
Name: _____
Relationship: _____
Phone: _____