Community Hospital
of the Monterey Peninsula
Montage Health

Sleep Disorders Center

Ryan Ranch Outpatient Campus
2 Upper Ragsdale Drive, Suite D-220
Monterey, California 93940
831-649-7210

Accredited by the American Academy of Sleep Medicine

Medical Director
Richard J. Kanak, MD, FCCP
Diplomate, American Board of Sleep

SLEEP DISORDERS QUESTIONNAIRE

Name: Date of birth:
MRN:

1. Who encouraged you to get a sleep disorders evaluation?
   (e.g. spouse, friend, doctor [please list name], hospital experience, your own concerns)
   _____
2. What do you hope to achieve from this consultation?
   _____
   _____
3. What time do you usually **get into** bed? _____
   a. **Weekdays/work or school days** _____
   b. **Weekends/days off** _____
4. Do you do any of the following in bed before turning out the lights?
   ☐ Watch TV ☐ Listen to music ☐ Read ☐ Work ☐ Computer/iPad, etc.
   Other bedtime habits: _____
5. What do you do for the hour before you get into bed?
   _____
6. How long does it usually take to fall asleep after turning off lights? (give a range)_____
7. Do you use or have you tried any **prescription *or* over-the-counter sleeping pills**?
   Current: _____
   Past: _____
8. Do you smoke cigarettes, use marijuana products or consume alcohol close to bedtime?
   ☐No ☐Yes (explain) _____
9. How often do you wake up at night? _____
10. Why do you wake up at night? ☐ Bathroom ☐ Snoring ☐ Trouble breathing
    ☐ Choking feeling ☐ Acid reflux or heartburn ☐ Leg pain/discomfort ☐ Jumpy legs
    ☐ Anxiety/worry ☐ Palpitations ☐ Pain
    other (explain) _____
11. Do you frequently eat/snack when you wake up at night? ☐ Yes ☐ No

12. If you wake at night, is it difficult to get back to sleep? ☐ Yes (explain) ☐ No

_____

_____

13. What time do you get up for **work or school** (if applicable)? _____
14. What time do you get up on **weekends or non-work days**? _____
15. Do you use an **alarm clock or clock radio** to help you wake up? ☐ Yes ☐ No
16. How much total sleep do you think you get most **work/school nights**?_____
17. How much total sleep do you think you get most **weekends or days off**?_____
18. Do you take naps during the day?
    a. ☐Never ☐1-2x weekly ☐3-4x weekly ☐5-6x weekly ☐everyday
    b. How long do you usually nap?_____
    c. Do you wake up from your naps rested/refreshed? ☐ Yes ☐ No ☐ Somewhat
19. Do you frequently travel across 2 or more time zones? ☐ Yes ☐ No
20. Do you or those who know you consider you a:
    a. "**night owl**" ☐ Yes ☐ No ☐ Somewhat
    b. "**morning person**" ☐ Yes ☐ No ☐ Somewhat
21. Do you worry or experience **anxiety about your sleep**?
    ☐ Never ☐ Occasionally ☐ Most nights
22. **Over the past few months**, how often do you experience these issues:
    a. **At bedtime, thoughts race through my mind**
       ☐ Never ☐ Occasionally ☐ Most nights
    b. **At bedtime, I worry about things**
       ☐ Never ☐ Occasionally ☐ Most nights
    c. **At bedtime, I'm afraid of not being able to go to sleep**
       ☐ Never ☐ Occasionally ☐ Most nights
    d. **After waking up at night, I'm afraid I will not get back to sleep**
       ☐ Never ☐ Occasionally ☐ Most nights
    e. **I sleep better in unfamiliar places such as a hotel room**
       ☐ Never ☐ Occasionally ☐ Most nights
23. What position(s) do you sleep in?
    ☐ Back ☐ Left side ☐ Right side ☐ Stomach ☐ Chair ☐ Hospital-type bed
24. Do you snore loud enough to **wake yourself up or disturb others**?
    ☐ Never ☐ Occasionally ☐ Most nights ☐ Only sleeping on my back
25. Have you been told that you **hold your breath** *or* **stop breathing while you sleep**?
    ☐ Yes ☐ No Explain: _____

_____

26. Do you wake up with a **choking feeling** at night?
☐ Never ☐ Occasionally ☐ Frequently

27. Do you wake up with **heartburn or acid reflux**?
☐ Never ☐ Occasionally ☐ Frequently

28. Do you **wake up from sleep** feeling **short of breath** or **gasping for air**?
☐ Yes ☐ No

29. Do you frequently wake up with a **dry mouth**? ☐ Yes ☐ No

30. Do you **wake up with a headache**?
☐ Never ☐ 1-3x/month ☐ 1-3x/week ☐ Most days

31. Do you grind your teeth or clench at night? ☐ **Grind** ☐ **Clench** ☐ Neither

32. Do you or have you ever used a **Nite (Bite) Guard** to protect your teeth? ☐ Yes ☐ No

33. Do you get up to **urinate at night**? ☐ Yes ☐ No How often? _____

34. Do you tend to **sweat heavily at night**? ☐ Never ☐ Occasionally ☐ Most nights

35. 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)?

36. Do you experience **muscle cramps in your legs at night**?
☐ Never ☐ Occasionally ☐ Most nights

37. Have you been told or noticed that your arms/legs jump or twitch when you sleep?
☐ Never ☐ Occasionally ☐ Most nights

38. 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 or massaging legs, pounding legs, walking)?
☐ Never ☐ 1-3 times per/month ☐ 1-3x/week ☐ Most days
• Describe the feeling: _____
• How old were you when the unpleasant restless leg/arm feelings started? _____

39. Have you ever woken up feeling like you were ***acting out a dream***, e.g. **kicking, punching, jumping out of bed in response to your dream**? ☐ Yes ☐ No

40. Do you **sleepwalk** *in past five years*? ☐ Yes ☐ No
Provide details if Yes _____

41. Have you had a **seizure (convulsion, epilepsy) while sleeping** *in past five years*?
☐ Yes ☐ No
If yes, describe what happened? _____
_____

42. Do you have difficulty with: ☐ **Short term memory** ☐ **Focus/concentration** ☐ Neither

43. **Most days** I wake up feeling:
    ☐ Full of energy and wide awake
    ☐ Somewhat rested, could probably use more sleep
    ☐ Still tired or sleepy

44. Do you **fall asleep unintentionally**? (work/meeting, school, reading, driving, TV etc.)
    ☐ Never ☐ Occasionally ☐ Most days
    Examples:_____

45. Do you **frequently** get **sleepy or drowsy while driving**?
    ☐ Yes ☐ No ☐ I do not drive

46. Do you often let someone else drive because of sleepiness or fatigue? ☐ Yes ☐ No

47. Over the past five years have you had any motor vehicle accidents or "near misses" while driving due to sleepiness, drowsiness or fatigue? ☐ Yes ☐ No

48. Did you ever drive your car somewhere, then not remember driving there? ☐ Yes ☐ No

49. Do you ever **fall asleep suddenly** during the day, without feeling sleep a few minutes earlier? ☐ Never ☐ Occasionally ☐ Frequently

50. How often do you **dream at night**? ☐ Never ☐ Occasionally ☐ Frequently

51. Do you experience **dreams during daytime naps**? ☐ Never ☐ Occasionally ☐ Often

52. Have you ever woken up feeling like your muscles were paralyzed and you couldn't move for a few seconds or minutes? ☐ Yes ☐ No

53. Have you ever felt like you:
    a. Started to dream before falling asleep ☐ Yes ☐ No
    b. Were still experiencing a dream after you woke up ☐ Yes ☐ No

54. 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, e.g. get "week knees" ☐ Yes ☐ No
    b. When you are angry ☐ Yes ☐ No
    c. When hearing or telling a joke ☐ Yes ☐ No

55. **Insomnia Severity Index**

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
A. Difficulty falling asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
B. Difficulty staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C. Problems waking up too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

D. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

E. How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing your quality of life?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

F. How **WORRIED/DISTRESSED** are you about your current sleep pattern?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

G. To what extent do you consider your sleep problem to **INTERFERE** with you daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory) CURRENTLY?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

56. **Epworth Sleepiness Score**

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, imagine how they would have affected you

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

Situation	Chance of dozing			
	Never	**Slight**	**Moderate**	**High**
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in a public place (e.g. a theater or 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 lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

57. The **Fatigue Severity Scale** (FSS) is a method of evaluating the impact of fatigue on you. Read each statement and rate your level of fatigue, selecting a number from 1 to 7 based on how accurately it reflects your condition during the past week, and the extent to which you agree or disagree that the statement applies to you.

It is important that you pick a number (1 to 7) for every question.

Fatigue Severity Scale Questionnaire							
During the past week, I have found that:	**Disagree ←----------→Agree**						
My motivation is lower when I am fatigued.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Exercise brings on my fatigue.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
I am easily fatigued.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with my physical functioning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue causes frequent problems for me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
My fatigue prevents sustained physical functioning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with carrying out certain duties and responsibilities.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue is among my three most disabling symptoms.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with my work, family, or social life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Total score:						

58. Over the past 2 weeks, how often have you been bothered by any of the following?

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
a. Feeling nervous, anxious or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying	☐	☐	☐	☐
c. Little interest or pleasure in doing things?	☐	☐	☐	☐
d. Feeling down, depressed or hopeless?	☐	☐	☐	☐

59. Past testing and treatment for sleep problems

☐ Past evaluation with a sleep specialist; if so where/who with?

_____

_____

☐ Past sleep study at home; if so with what doctor or company?

_____

☐ Past sleep study overnight at a sleep testing facility; if so where?

_____

_____

☐ Past or current use of **CPAP or bilevel PAP** machine at home

☐ Past **surgical treatment for sleep apnea**

☐ Past or current use of a **dental appliance to treat sleep apnea**

☐ Past or current treatment for **restless legs**

☐ Past or current treatment for **REM sleep behavior disorder**

☐ Past or current non-medication treatments for insomnia, e.g. cognitive behavioral therapy

☐ Any other past evaluation or treatment for sleep problems

60. Over the past month, how much of a problem were the following conditions for you?

	None	Very mild	Moderate	Fairly bad	Severe
a. Nasal congestion or stuffiness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
b. Nasal blockage or obstruction	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
c. Trouble breathing thru nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
d. Unable to get enough air thru my nose during exertion or exercise	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
e. Trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

61. Check any of these childhood diseases you recall having:

☐ Whooping cough ☐ Polio

☐ Rheumatic fever ☐ Chicken pox

62. Check any of these medical problems you have now or in the past?

- ☐ Narcolepsy
- ☐ Sleep apnea
- ☐ TMJ disorder
- ☐ Dentures
- ☐ Loose/missing teeth
- ☐ Restless legs
- ☐ Iron-deficiency
- ☐ Anemia
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Chronic fatigue
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Fibromyalgia
- ☐ Other persistent pain
- ☐ Where? _____ _____
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Rheumatoid arthritis
- ☐ Scleroderma
- ☐ Lupus
- ☐ HIV infection
- ☐ GERD/acid reflux
- ☐ Nose sinus allergies
- ☐ Allergy shots
- ☐ Eczema
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Chronic bronchitis
- ☐ Pulmonary fibrosis
- ☐ Sarcoidosis
- ☐ Valley fever (Cocci)
- ☐ Asbestos lung disease
- ☐ Tuberculosis
- ☐ Other lung disease _____ _____
- ☐ Enlarged prostate
- ☐ Bladder problems
- ☐ Parkinson's
- ☐ Seizures/epilepsy
- ☐ Dementia
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Alcohol abuse
- ☐ Cocaine use
- ☐ Methamphetamine use
- ☐ Other drug use _____
- ☐ High blood pressure
- ☐ Cholesterol/lipid problems
- ☐ Diabetes
- ☐ Atrial fibrillation or flutter
- ☐ Heart rhythm problem
- ☐ Heart attack
- ☐ Stroke
- ☐ TIA
- ☐ Congestive heart failure
- ☐ Pulmonary hypertension
- ☐ Blood clots in leg
- ☐ Blood clots in lung
- ☐ Underactive thyroid
- ☐ Goiter
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Gallstones
- ☐ Liver disease
- ☐ Ulcerative colitis
- ☐ Crohn's disease

63. Have you had a **tuberculosis test** (skin test "PPD", or blood test "Quantiferon Gold"):

Quantiferon Gold	☐ not done	Year:	☐ normal	☐ abnormal
PPD (TB skin test)	☐ not done	Year:	☐ normal	☐ abnormal

Have you ever received any **treatment for tuberculosis**? ☐ Yes ☐ No

64. List any forms of **cancer/malignancy** you have or had in past: _____

_____

_____

65. Other major medical problems not listed above (***list surgery, operations on next page***)

_____

_____

66. Check or list all **surgery/medical procedures** you remember having:

☐ Tonsils removed	☐ Adenoids removed	☐ Sinus surgery
☐ Nasal septum repaired	☐ Soft palate/uvula	☐ Tongue surgery
☐ Jaw surgery	☐ Heart bypass	☐ Heart valve replaced
☐ Heart stent or angioplasty	☐ Other stent or angioplasty	☐ Pacemaker ***or*** defibrillator
☐ Gallbladder removed	☐ Lung surgery	☐ Ulcer surgery
☐ Gastric bypass	☐ Gastric lap band	☐ Gastric sleeve
☐ Surgery for GERD/acid reflux	☐ Appendix removed	☐ Hysterectomy
☐ Hip replacement	☐ Knee replacement	☐ Prostate surgery
☐ Cataract surgery	☐ Retinal surgery	☐ Glaucoma surgery

Other surgery/procedures: _____

_____

_____

67. 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/strength**	**When/how often you take it**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

68. List all **over-the-counter medicine** you take, e.g. vitamins, minerals, supplements, herbals

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

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

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

70. Have you had **x-ray test where dye (contrast) was injected into your blood?**
☐ Yes ☐ No

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

_____

71. Have you ever received: C**hemotherapy** ☐ Yes ☐ No **Radiation therapy**? ☐ Yes ☐ No
Provide details? _____

_____

72. Have you ever **donated blood**? ☐ Yes ☐ No When? _____

73. Have you ever received a **blood transfusion**? ☐ Yes ☐ No When? _____

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

75. Have you been **exposed to any of these**?

☐ Exotic birds or bird feathers currently ☐ Grain dust ☐ Moldy hay
☐ Hot tub/spa at home currently ☐ Asbestos ☐ Beryllium
☐ Sandblasting ☐ Welding ☐ Heavy metals
☐ Pesticides ☐ Solder ☐ Baking flour dust
☐ Other (explain) _____

76. Home relationships:

a. ☐ Married/long-term relationship ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

b. ☐ My spouse/significant other sleeps in a separate bed or separate bedroom

77. Who lives at home with you? _____

78. Where did you grow up?_____

How long have you lived locally?_____

Where else have you lived and when? _____

79. What is your highest level of school attended?_____

80. Are you currently?

☐ Self-employed ☐ An Employee ☐ Unemployed ☐ Retired ☐ Disabled

81. What is your current or most recent occupation? _____

82. What other type of work have you done in the past? _____

_____

83. Describe any military experience: _____

84. List travel outside the United States in the past 5 years _____

_____

85. Describe your diet: _____

86. Describe your usual exercise: _____

87. Do you currently smoke:

☐ Vape or E-cigarettes ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Marijuana

How much do you smoke? _____

88. If you quit smoking, describe your past smoking habits: ***how much & how long***?

_____

☐ I never smoked

89. How ***often*** do you have a drink containing alcohol?

☐ I never drank alcohol in my life
☐ Never
☐ Monthly or less
☐ 2-4x/month
☐ 2-3x/week
☐ 4 or more times/week

90. How many standard drinks containing alcohol do you have on a ***typical day***?

☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-9
☐ 10 or more

91. How often do you have six or more drinks ***on one occasion***?

☐ Never
☐ less than monthly
☐ 2-4x/month
☐ 2-3x/week
☐ 4 or more times/week

92. Do you drink any **caffeinated beverages**?

☐ **Coffee** How much? _____
☐ **Tea** How much? _____
☐ **Cola/mountain dew** How much? _____
☐ **Energy drinks** How much? _____

Latest time of you usually consume caffeine? _____

93. List any **pets/animals at home**, including birds, rodents, reptiles, farm/ranch animals

_____

94. List **which family members** have the following problems:

☐ **Sleep apnea**	☐ **Loud snoring**
☐ **Narcolepsy**	☐ **Restless legs**
☐ **Sleep walking**	☐ **Long-term insomnia**
☐ **Depression**	☐ **Anxiety disorder**
☐ **High blood pressure**	☐ **Diabetes**
☐ **High cholesterol or triglycerides**	☐ **Heart attack or clogged arteries**
☐ **Congestive heart failure**	☐ **Stroke**
☐ **Asthma**	☐ **Nasal allergies**, e.g. pollen, dust, cat
☐ **Blood clots in legs or lung**	☐ **Parkinson's**
☐ **Dementia or Alzheimer's**	☐ Other:

95. **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				
Mother				

*Complete for **brothers, sisters, sons, daughters –** please **list them even if healthy***

Relative	Age	Alive?	Cause of death	Major health problems

96. **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? _____

What is your neck/collar size (if known)? _____

What is your most recent weight? _____

Estimate your weight 1 year ago? _____

Estimate your weight 5 years ago? _____

Estimate your weight 10 years ago? _____

Estimate your weight at age 21? _____

Have you experienced any of these ***within past month***?

Yes	No	Constitutional
☐**Y**	☐**N**	Loss of appetite
☐**Y**	☐**N**	Weight loss
☐**Y**	☐**N**	Weight gain
☐**Y**	☐**N**	Chills or fevers
☐**Y**	☐**N**	Heavy sweating at night
☐**Y**	☐**N**	Fatigued/tired

Yes	No	Eye
☐**Y**	☐**N**	Recent change in vision
☐**Y**	☐**N**	Itchy eyes
☐**Y**	☐**N**	Watery eyes
☐**Y**	☐**N**	Dry eyes
☐**Y**	☐**N**	Eye pain

Yes	No	ENT
☐**Y**	☐**N**	Hearing loss
☐**Y**	☐**N**	Ringing in ears
☐**Y**	☐**N**	Impaired smell
☐**Y**	☐**N**	Impaired taste
☐**Y**	☐**N**	Frequent bad breath
☐**Y**	☐**N**	Recurring nose bleeds
☐**Y**	☐**N**	Sneezing
☐**Y**	☐**N**	Nasal congestion
☐**Y**	☐**N**	Nasal spray (e.g. Afrin, 4-way, Dristan)
☐**Y**	☐**N**	Post-nasal drip
☐**Y**	☐**N**	Frequently clear throat
☐**Y**	☐**N**	Hoarse voice
☐**Y**	☐**N**	Sore throat

Yes	No	Cardiovascular
☐**Y**	☐**N**	Chest pain or pressure
☐**Y**	☐**N**	Palpitations
☐**Y**	☐**N**	Rapid heart beat

Yes	No	Respiratory
☐**Y**	☐**N**	Cough
☐**Y**	☐**N**	Sputum production
☐**Y**	☐**N**	Coughing up blood
☐**Y**	☐**N**	Trouble breathing with exertion
☐**Y**	☐**N**	Trouble breathing lying down
☐**Y**	☐**N**	Waking up at night with difficulty breathing
☐**Y**	☐**N**	Wheezing
☐**Y**	☐**N**	Chest tightness

Yes	No	Gastrointestinal
☐**Y**	☐**N**	Nausea or vomiting
☐**Y**	☐**N**	Difficulty swallowing
☐**Y**	☐**N**	Pain when swallowing
☐**Y**	☐**N**	Acid reflux
☐**Y**	☐**N**	Heart burn
☐**Y**	☐**N**	Bloated feeling
☐**Y**	☐**N**	Excessive burping
☐**Y**	☐**N**	Passing excessive gas

Have you experienced any of these ***within past month***?

Yes	No	Musculoskeletal
☐**Y**	☐**N**	Muscle pain

Where? _____

☐**Y**	☐**N**	Leg cramps at night
☐**Y**	☐**N**	Joint pain

Where? _____

☐**Y**	☐**N**	Joint stiffness

Where? _____

Yes	No	Skin
☐**Y**	☐**N**	Current skin rash
☐**Y**	☐**N**	Frequent itching
☐**Y**	☐**N**	Current skin cancer
☐**Y**	☐**N**	Other skin problem

Explain: _____

Yes	No	Neurologic
☐**Y**	☐**N**	Frequent headaches
☐**Y**	☐**N**	Recent seizure
☐**Y**	☐**N**	Recent stroke
☐**Y**	☐**N**	Difficulty walking
☐**Y**	☐**N**	Difficulty speaking
☐**Y**	☐**N**	Memory loss
☐**Y**	☐**N**	Hand tremor
☐**Y**	☐**N**	Sensation of room spinning

Yes	No	Psychologic
☐**Y**	☐**N**	Depression
☐**Y**	☐**N**	Anxiety/nervousness
☐**Y**	☐**N**	Hallucinations
☐**Y**	☐**N**	Paranoid thoughts
☐**Y**	☐**N**	Claustrophobia

Yes	No	Endocrine
☐**Y**	☐**N**	Poor tolerance of cold
☐**Y**	☐**N**	Poor tolerance of heat
☐**Y**	☐**N**	Extreme thirst
☐**Y**	☐**N**	Loss of interest in sex
☐**Y**	☐**N**	Poor sexual function

Yes	No	Heme & Lymphatic
☐**Y**	☐**N**	Anemia (low red cells)
☐**Y**	☐**N**	Iron deficiency
☐**Y**	☐**N**	Swollen glands:

Where? _____

☐**Y**	☐**N**	Easy bleeding
☐**Y**	☐**N**	Easy bruising

Yes	No	Allergic & Immunologic
☐**Y**	☐**N**	Immune deficiency:

Explain: _____

☐**Y**	☐**N**	Autoimmune disorder

Explain: _____

Yes	No	Genitourinary system
☐**Y**	☐**N**	Difficult-slow urination
☐**Y**	☐**N**	Urinate at night?

How often? _____

☐**Y**	☐**N**	Poor bladder control

Women only

How many pregnancies?_____

How many miscarriages?_____

Are you still menstruating?_____

Age at time of menopause? _____

Unusually prolonged or heavy bleeding?

☐ Yes ☐ No

Hysterectomy

☐ Yes ☐ No

Age at time of hysterectomy _____