Virginia Baptist Hospital
Lynchburg, Virginia
Phone (434) 200-4628
Fax (434) 200-4400

Centra Health Sleep Disorder Centers
Health History Questionnaire

Southside Community Hospital
Farmville, Virginia
Phone (434) 200-4628
Fax (434) 200-4400

Name:_____ **DOB:**_____ **Ht:**_____ **Wt:**_____ **Neck Circumference:**_____

Reason for visit: _____

Please list any medical problems or previous surgeries: _____

_____

_____

MEDICATIONS (PLEASE PROVIDE CURRENT LIST IF POSSIBLE):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment Status: ☐ Working, Occupation:_____ ☐ Retired ☐ Disabled ☐ Unemployed

Have you ever smoked tobacco? ☐ Yes ☐ No If Yes,are you still smoking? ☐ Yes ☐ No

If yes: How many packs per day?_____ How many years have you smoked?_____

Do you drink alcohol? ☐ Yes ☐ No If yes,how many servings a week?_____

Have you used recreational drugs? ☐ Yes ☐ No If yes, what? _____ How Often?_____

How many servings of caffeine do you drink per day? _____

Check ALL that apply:

General: ☐ Weight change ☐ Fatigue ☐ Fever ☐ Sweats ☐ Appetite Loss	**Lungs:** ☐ Asthma ☐ Wheezing ☐ Cough ☐ COPD ☐ Pain Breathing ☐ Shortness of Breath	**Heart/Vascular:** ☐ Chest Discomfort ☐ Leg Cramps ☐ Breathlessness While Laying Flat ☐ Leg Swelling ☐ Irregular Heartbeat

Eyes/Ears/Nose/Throat/Mouth: ☐ Vision Changes ☐ Nasal Congestion ☐ Hearing Loss ☐ Seasonal Allergies	**Neuro:** ☐ Dizziness ☐ Memory Loss ☐ Blackouts ☐ Seizures ☐ Headaches	**Psychiatric:** ☐ Depression ☐ Anxiety ☐ Panic Attacks

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Name:_____ **DOB:**_____

SLEEP HABITS:

1. Regular bedtime?_____
2. Regular wake up time?_____
3. Are you excessively sleepy during the day? ☐ Yes ☐ No
4. Do you take naps during the day? ☐ Yes ☐ No
5. Do you sleep alone? ☐ Yes ☐ No
6. Are you a shift worker? ☐ Yes ☐ No
7. Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No
8. If yes, were you treated? ☐ Yes ☐ No

i. If yes, do you still use treatment? ☐ Yes ☐ No

1. If yes, are you compliant with therapy? ☐ Yes ☐ No

How likely are you to doze off or fall asleep under the following situations? Circle the appropriate number.

0 = Never 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place	0	1	2	3
A passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped at a traffic light	0	1	2	3

Total: _____

Check all that apply:

Sleep: ☐ Toss & Turn ☐ Stops/pauses breathing ☐ Snoring/snorting ☐ Wake up gasping/snorting/choking ☐ Insomnia ☐ Nightmares ☐ Excessive Movement/discomfort in legs ☐ Headache upon waking ☐ Abnormal Sleepiness ☐ Unable to sleep flat ☐ Bed Wetting ☐ Frequent night-time urination ☐ Sleepiness while driving ☐ Feel paralyzed upon waking/dozing off ☐ Wake with dry mouth ☐ Heartburn ☐ Unusual behavior observed during sleep ☐ Sleep talking ☐ Teeth Grinding

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If possible, please have your bed partner or a family member fill out.

Please check any of the following behaviors that have been observed

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Pauses in breathing
- ☐ Sleep talking
- ☐ Sleep walking
- ☐ Sitting up in bed while sleeping
- ☐ Getting out of bed while asleep
- ☐ Head rocking or banging
- ☐ Becoming very rigid and/or shaking
- ☐ Twitching of legs or feet
- ☐ Kicking with legs or feet

How long have you been aware of the sleep behavior(s) that you have checked? _____

_____

Describe these behaviors or any other unusual behaviors in more detail. Include a description of the activity, how often it happens during the night and how many times a week.

_____

_____

_____

_____

_____

_____

_____

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