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

Forest Sleep Disorders Center
Forest, Virginia
Phone (434) 455-0626
Fax (434) 200-4400

Southside Community Hospital
Farmville, Virginia
Phone (434) 315-2407
Fax (434) 315-2408

Centra Sleep Disorder Centers
Health History Questionnaire

Please email to sleepcenter@centrahealth.com or fax to the numbers above.

Date _____ **MR #** _____

Name _____ **Age** _____ **DOB** _____

Height _____ **Weight** _____ **Neck Circumference** _____

How likely are you to doze off or fall asleep under the following situations?	**Never 0**	**Slight Chance 1**	**Moderate Chance 2**	**High Chance 3**
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
A passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking with someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
In a car, while stopped at a traffic light	☐	☐	☐	☐

Reason for today's visit: _____

List Medical Problems & Surgeries:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List Medication Allergies: _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____

Employment Status: ☐ Working ☐ Retired ☐ Disabled ☐ Unemployed

Have you ever smoked tobacco? ☐ Yes ☐ No Are you still smoking? ☐ Yes ☐ No

How many packs per day? _____ How many years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No How many servings a week? _____

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

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

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Health History Questionnaire

Name _____ **DOB** _____ **MR #** _____

Check **ALL** that apply:

SLEEP:

☐ Toss & Turn	☐ Stop Breathing (Pauses)	☐ Snoring	☐ Wake Up Gasping
☐ Insomnia	☐ Nightmares	☐ Restless Legs (Excessive Movement)	
☐ Headaches Upon Awakening	☐ Abnormal Sleepiness	☐ Unable to Sleep Flat	☐ Bed-Wetting
☐ Frequent Urination	☐ Sleepiness While Driving	☐ Feel Paralyzed Upon Awakening or Dozing Off	
☐ Waking Up With Dry Mouth	☐ Heartburn	☐ Snorting	☐ Sleep Talking
☐ Sleep Walking	☐ Teeth Grinding	☐ Unusual Behavior Observed During Sleep	

GENERAL:

☐ Weight Change ☐ Fatigue ☐ Fever
☐ Sweats ☐ Appetite Loss

LUNGS:

☐ Asthma ☐ Wheezing ☐ COPD ☐ Cough
☐ Shortness of Breath ☐ Pain in Breathing

EYES / EARS / NOSE / THROAT / MOUTH:

☐ Vision Changes ☐ Nasal Congestion
☐ Hearing Loss ☐ Seasonal Allergies

HEART / VASCULAR:

☐ Chest Discomfort ☐ Leg Cramps ☐ Leg Swelling
☐ Breathlessness While Lying Flat ☐ Irregular Heartbeat

NEURO:

☐ Dizziness ☐ Blackouts ☐ Seizures
☐ Headaches ☐ Memory Loss

PSYCHIATRIC:

☐ Depression ☐ Anxiety ☐ Panic Attacks

SLEEP HABITS:

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

MEDICATION LIST (Please Attach Medication List if Possible):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you on Oxygen? ☐ Yes ☐ No

_____
Signature Date/Time

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Health History Questionnaire

Please have your bed partner or a family member fill out.

Patient Name _____ **DOB:** _____ **Filled out by** _____

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.

_____

_____

_____

_____

_____

_____

_____

Patient Label