Please fill out this questionnaire and bring it with you to your scheduled appointment. Thank you.

Name: ___________________________ D.O.B.: ____________ Sex: M  F  Marital Status: ________

Height: ________ Allergies to Medicines: ____________________________

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**SLEEP HISTORY QUESTIONNAIRE**

Memorial Hospital
Belleville, Illinois 62226

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**SLEEP HISTORY QUESTIONNAIRE**

CM684-004  R07/07
Page 1 of 2

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**SLEEP HISTORY QUESTIONNAIRE**

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**SLEEP HABITS**

1. What is your normal bedtime? _____ AM    PM
2. What time do you usually wake up? _____ AM    _____ PM
3. How long does it usually take you to fall asleep? ______
4. How many times during your sleep do you wake up? ______
5. Do you usually only wake up to use the restroom? ______
6. How many naps do you take in a typical week? ______ For how long?

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**SLEEP PROBLEMS**

In your own words, briefly describe your sleep-related problem:

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1. Do you sleep with someone in your bed? YES NO
2. Does your bed partner complain about you snoring? YES NO
3. Does your bed partner ever report that you stop breathing while sleeping? YES NO
4. Does your snoring awaken you while sleeping? YES NO
5. Do you ever feel unpleasant sensations in your legs? (crawling feeling, aching, pain, urge to move a lot) YES NO
6. Are you often very tired during the day? YES NO

---

**WHEN FALLING ASLEEP HOW OFTEN DO YOU:**

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Suddenly wake up gasping for breath?</td>
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<td>12. Wake up violent or confused?</td>
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<td>2. Wake up with a very dry mouth?</td>
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<td>13. Have nightmares?</td>
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<td>3. Have difficulty falling asleep?</td>
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<td>14. Wet the bed?</td>
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<td>4. Have difficulty staying asleep?</td>
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<td></td>
<td>15. Wake up with a headache?</td>
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<tr>
<td>5. Do you fall asleep at unwanted times?</td>
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<td>16. Wake up sick to your stomach?</td>
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<td>6. Depend on an alarm to wake up?</td>
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<td>17. Wake up with jaw pain?</td>
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<td>7. Sleep an hour past your normal wake up time?</td>
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<td>18. Grind your teeth while sleeping?</td>
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<td>8. Have restless, disturbed sleep?</td>
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<td>19. Do you have anxiety or disturbing thoughts?</td>
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<td>9. Feel your heart racing at night?</td>
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<td>20. Do you feel weakness in your muscles when laughing, surprised or excited?</td>
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<td>10. Sweat during your sleep?</td>
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<td>11. Walk in your sleep?</td>
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</tbody>
</table>

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Please List All of Your Current Medications and Dosages:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
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<tbody>
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</tbody>
</table>

**Health History**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Have you ever been diagnosed with a sleep disorder?</td>
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<td>2. Have you ever had your tonsils or adenoids removed?</td>
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<tr>
<td>3. Does anyone in your family have a sleep disorder?</td>
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</tbody>
</table>

Please check any of these illnesses that you have or have had in the past:

- Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Abnormal Thyroid
- Congestive Heart Failure
- Seizures
- Diabetes
- Asthma
- Hearing Trouble
- Nasal Congestion
- Prostate Problems
- Mental Problems
- Fainting
- Impotence
- Bladder Trouble
- Depression
- Impotence
- Bladder Trouble
- Depression
- Hearing Trouble
- Nasal Congestion
- Prostate Problems
- Mental Problems
- Fainting
- Seizures
- Diabetes
- Asthma

Please list any surgeries that you have had:

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

**General History**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you smoke cigarettes?</td>
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<tr>
<td>2. Do you exercise?</td>
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<td>3. Do you drink alcohol?</td>
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<td>4. Do you drink caffeine?</td>
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<td>5. Do you use over the counter sleeping pills to help you sleep?</td>
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<td>6. Does your sleep problem interfere with work or school?</td>
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<td>7. What is your occupation?</td>
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<td>8. What are your normal work/school hours?</td>
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</tbody>
</table>

If yes, how many packs per day?  _______ How many years?  _______
If yes, how often?  __________
If yes, how much per day?  __________
If yes, how much per day?  __________
If so, what kind?  __________

If it become necessary, is there any family or friends that we may share your health information with, other than healthcare providers participating in your care?

Name: __________________________ Relationship: __________
Name: __________________________ Relationship: __________

Do you have a Living Will?  Yes  No  If not, would you like information on obtaining one?  Yes  No