

Sleep Profiler Medical History Questionnaire

PLEASE PRINT IN CAPITAL LETTERS. STAY WITHIN THE BOX.

First Name		Middle Initial		Last Name	
Weight	Pounds	Age		Years	Gender Male <input type="radio"/> Female <input type="radio"/>
Height	Feet	Inches		Neck Size	Inches
Date of Birth	Month	Day	Year	ID Number	Optional

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions or have the following symptoms?					
High Blood Pressure	Yes <input type="radio"/> No <input type="radio"/>	Heart Disease	Yes <input type="radio"/> No <input type="radio"/>	Diabetes	Yes <input type="radio"/> No <input type="radio"/>
Restless Leg Syndrome	Yes <input type="radio"/> No <input type="radio"/>	Sleep Apnea	Yes <input type="radio"/> No <input type="radio"/>	Insomnia	Yes <input type="radio"/> No <input type="radio"/>
Narcolepsy	Yes <input type="radio"/> No <input type="radio"/>	Depression	Yes <input type="radio"/> No <input type="radio"/>	Anxiety or PTSD	Yes <input type="radio"/> No <input type="radio"/>
Recent Head Trauma	Yes <input type="radio"/> No <input type="radio"/>	Stroke	Yes <input type="radio"/> No <input type="radio"/>	Neurological Disorder	Yes <input type="radio"/> No <input type="radio"/>
Painful Condition	Yes <input type="radio"/> No <input type="radio"/>	A.M. Headaches	Yes <input type="radio"/> No <input type="radio"/>	Night Sweats	Yes <input type="radio"/> No <input type="radio"/>

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze	2 = moderate chance of dozing	0	1	2	3
1 = slight chance of dozing	3 = high chance of dozing				
Sitting and reading		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting inactive in a public place (theater, meeting, etc)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rate the CURRENT (i.e., LAST TWO WEEKS) SEVERITY of your insomnia problem(s)					
Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem waking up too early	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How SATISFIED or DISSATISFIED are you with your CURRENT sleep pattern?					
Very Satisfied <input type="radio"/>	Satisfied <input type="radio"/>	Moderately Satisfied <input type="radio"/>	Dissatisfied <input type="radio"/>	Very Dissatisfied <input type="radio"/>	
How NOTICABLE to others do you think your sleep problem is in terms of impairing the quality of your life?					
Not at all Noticable <input type="radio"/>	A Little <input type="radio"/>	Somewhat <input type="radio"/>	Much <input type="radio"/>	Very Much Noticeable <input type="radio"/>	
How WORRIED / DISTRESSED are you about your current sleep problem?					
Not at all Worried <input type="radio"/>	A Little <input type="radio"/>	Somewhat <input type="radio"/>	Much <input type="radio"/>	Very Much Worried <input type="radio"/>	
To what extent do you consider your sleep problem to INTERFERE with your CURRENT functioning (e.g. daytime fatigue, ability to function at work / daily chores, concentration, memory, mood, etc.)?					
Not at all Interfering <input type="radio"/>	A Little <input type="radio"/>	Somewhat <input type="radio"/>	Much <input type="radio"/>	Very Much Interfering <input type="radio"/>	
How often during the week do you drink alcoholic beverages in the evening before falling asleep?					
Never <input type="radio"/>	1-2 Times <input type="radio"/>	2-3 Times <input type="radio"/>	4-5 Times <input type="radio"/>	Always 6-7 Times <input type="radio"/>	
Do you drink more than one beverage with caffeine in the afternoon or evening (i.e., coffee, tea, energy or soft drinks)?					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>	

Please turn over and complete side two.

For these questions:	Rarely = 0-1 times/week	Sometimes = 1-2 times/wk	Frequently = 3-4 times/wk	Almost Always = 5+ times/wk
Do you have problems keeping your legs still at night or need to move them to feel comfortable?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
Do you have vivid or troubling nightmares?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
On average, in the past month, how often have you snored or been told that you snored?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
Do you wake up choking or gasping?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
Have you been told that you stop breathing in your sleep or wake up choking or gasping?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
How often do you take a prescription medication to help you fall sleep or stay asleep?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>
How often do you take an 'Over the Counter' medication to help you fall asleep or stay asleep?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost Always <input type="radio"/>

Patient Health Questionnaire (PHQ-9): Over the last 2 weeks, how often have you been bothered by any of the following problems?					
0 = not at all 1 = several days	2 = more than half the days 3 = nearly every day	0	1	2	3
Little interest or pleasure in doing things		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Generalized Anxiety Disorders (GAD-7): Over the last 2 weeks, how often have you been bothered by any of the following problems?					
0 = not at all 1 = several days	2 = more than half the days 3 = nearly every day	0	1	2	3
Feeling nervous, anxious, or on edge		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being too restless so that it is hard to sit still		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you routinely take any of the following medications?											
Ambien (zolpidem)	Yes <input type="radio"/>	No <input type="radio"/>	Lunesta (eszopiclone)	Yes <input type="radio"/>	No <input type="radio"/>	Halcion	Yes <input type="radio"/>	No <input type="radio"/>			
Rozerem	Yes <input type="radio"/>	No <input type="radio"/>	Sonata (zaleplon)	Yes <input type="radio"/>	No <input type="radio"/>	Restoril	Yes <input type="radio"/>	No <input type="radio"/>			
Intermezzo	Yes <input type="radio"/>	No <input type="radio"/>	Silenor (doxepin)	Yes <input type="radio"/>	No <input type="radio"/>	Xanax	Yes <input type="radio"/>	No <input type="radio"/>			
Narcotic for Pain	Yes <input type="radio"/>	No <input type="radio"/>	High Blood Pressure	Yes <input type="radio"/>	No <input type="radio"/>	Steroid	Yes <input type="radio"/>	No <input type="radio"/>			
Heart Disease	Yes <input type="radio"/>	No <input type="radio"/>	Antidepressant	Yes <input type="radio"/>	No <input type="radio"/>	Parkinson's	Yes <input type="radio"/>	No <input type="radio"/>			
Antihistamines	Yes <input type="radio"/>	No <input type="radio"/>	Anti-anxiety/tranquilizer	Yes <input type="radio"/>	No <input type="radio"/>	Stimulant/ADHD	Yes <input type="radio"/>	No <input type="radio"/>			
Signature						Area Code	Phone Number				