Dedicated Sleep

# COMPREHENSIVE HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering the questions. Your partner may be able to assist you.

***Please remember to write your name at the top of each page.**

**General Information** *(This information will become part of your medical record and will remain confidential.)*

| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | | | Date: | |
| (First) | (Middle) | (Last) | | | |
| Address: | | | | | |
| (Street) | | | (City) | (State) | (Zip) |
| Home Phone | | | Work Phone: | | |
| Cell Phone: | | | May we call you at work? | | |
| Email: | | | Best way to reach you? | | |
| Date of Birth: | | Age: | | Sex: Male | Female |
| Height:_____ | Weight:_____lbs. | Marital Status: | ☐ Single | ☐ Widowed | |
| | | | ☐ Divorced | ☐ Married/Partner | |
| SSN: | | Occupation: | | | |
| Emergency Contact: | | Relationship: | | Phone Number: | |
| Referring Physician: | | | Primary Care Physician: | | |
| Cardiologist: | | | Pulmonologist: | | |

List current medical conditions for which you are being treated.

| Diagnosis | Year | Treating Physician |
|---|---|---|
| | | |
| | | |
| | | |

List all hospitalizations and surgeries you have had. (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

| Diagnosis | Year | Treating Physician |
|---|---|---|
| | | |
| | | |
| | | |

List medications you are currently taking. (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

| Medication | Reason | Dosage | How often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list any allergies we should be aware of:

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Patient Name: DOB: DOS:

| Health Questions *(Please answer the best you can)* | | |
|---|---|---|
| Are you unable to sleep in a flat position due to shortness of breath? | ☐ Yes | ☐ No |
| Do you have a family history of snoring or other sleep disorders? | ☐ Yes | ☐ No |
| If yes, please describe: | | |
| Have you ever sustained a brain concussion, head injury or serious blow to the head? | ☐ Yes | ☐ No |
| Do you have spells or seizures? | ☐ Yes | ☐ No |
| Do you have high blood pressure? | ☐ Yes | ☐ No |
| Have you experienced a weight gain in the last year? | ☐ Yes | ☐ No |
| If yes, how much weight? | | |
| Has your shirt collar size increase recently? | ☐ Yes | ☐ No |
| If yes, by how much? | | |
| Do you smoke? | ☐ Yes | ☐ No |
| How many packs per day? How long have you smoked? | | |
| Have you quit smoking? | | |
| How many packs per day prior to quitting? How long did you smoked? Year quit? | | |
| Do you drink alcohol? | ☐ Yes | ☐ No |
| If yes, please estimate the number of drinks per day. (beer, wine, or liquor) | | |
| Do you drink caffeinated drinks? | ☐ Yes | ☐ No |
| If yes, please estimate the number of drinks per day. (sodas, coffee, or tea) | | |
| (Female) Have you gone through menopause? | ☐ Yes | ☐ No |
| (Males) Have you experience any prostate issues? (i.e. Frequent urination) | ☐ Yes | ☐ No |

**Sleep Health Concerns & Habits**

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

| | | | | | |
|---|---|---|---|---|---|
| Has this been a continuous problem? | | ☐ Comes and goes | ☐ Occasional | ☐ Frequent | ☐ Constant |
| How long has your sleep problem bothered you? | ☐ Greater than 2yrs. | ☐ 1-2 yrs. | ☐ Several Months | ☐ Last 3 Months | ☐ Within the month |
| What time do you usually go to bed? | Week Days: | | Weekends: | | |
| What time do you usually wake up? | Week Days: | | Weekends: | | |
| How many hours of sleep do you usually get per night? | | | | | |
| How long does it take you to fall asleep? | | | | | |
| If you awake in the middle of the night, how long are you typically awake for? | | | | | |
| Which shift do you work? (Check all that apply) | ☐ Day | | ☐ Evening | | ☐ Night |

| Sleep Questions | Never | Rarely | Often | Frequent | Always |
|---|---|---|---|---|---|
| How often do you rotate shifts? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does your job require overnight travel? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you drink alcohol at 6pm? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you drink caffeinated beverages after 6pm? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you suffer from a loss of libido? | ☐ | ☐ | ☐ | ☐ | ☐ |
| (Males) Have you experienced difficulties with sexual functions? | ☐ | ☐ | ☐ | ☐ | ☐ |

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Patient Name: DOB: DOS:

| Sleep Questions | Never | Rarely | Often | Frequent | Always |
|---|---|---|---|---|---|
| (Females) Does your sleep problem vary according to the stage of your menstrual cycle? | ☐ | ☐ | ☐ | ☐ | ☐ |
| (Females) Have you gone through menopause or had a hysterectomy? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you nap during the day or evening? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you feel refreshed after a typical night's sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you feel sleepy during the day even when you have slept all night? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you feel refreshed after a short nap? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you get sleepy while driving? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Have you had an accident or near-accident when driving, due to excessive sleepiness? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you able to fight off the excessive sleepiness? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have memory or concentration problems? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you experience vivid dream-like scenes upon awakening or falling asleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| When you are angry or laugh, do you ever feel weak, as though you might fall? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you ever unable to move or speak upon falling asleep or awakening? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have trouble falling asleep when you go to bed? | ☐ | ☐ | ☐ | ☐ | ☐ |
| When you try to fall asleep does your mind race with thoughts? | ☐ | ☐ | ☐ | ☐ | ☐ |
| When you try to fall asleep do you feel pain? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you a light sleeper, easily awakened? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Is your sleep disrupted because of your bed partner or others in your household? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does your snoring stop for brief periods during sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does your breathing sometimes stop during sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Is your bed partner disturbed by your snoring? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you wake up choking or gasping for breath? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have night sweats? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have heartburn at night? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have nasal / sinus congestion at night? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have morning headaches? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you a restless sleeper, tossing and turning at night? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have a creeping or crawling sensation in your legs when you lie down to sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you experience any type of leg or back pain during the night? | ☐ | ☐ | ☐ | ☐ | ☐ |

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Patient Name: DOB: DOS:

Rate the Following from 1-10 (one being less 10 being most painful):

Facial Pain:
Headaches:
Jaw Pain:
Ear Pain:
Neck Pain:
Front/Back Head Pain:

Pain Spreads to When Having Pain: ☐ Temple ☐ Back of Head ☐ Sensitivity to Light ☐ Nausea ☐ Vomiting ☐ Dizziness

## Temporomandibular Joint Disorder (TMJ/TMD) & Pain Concerns

| Symptom Questions | Right Side | Left Side | | Right Side | Left Side |
|---|---|---|---|---|---|
| Migraine Headaches | ☐ | ☐ | Pain in facial area | ☐ | ☐ |
| Do you have pain around/behind the eyes? | ☐ | ☐ | Grating sound in joint | ☐ | ☐ |
| Pain in jaw | ☐ | ☐ | Subjective hearing loss | ☐ | ☐ |
| Pain in neck | ☐ | ☐ | Dizziness (vertigo) | ☐ | ☐ |
| Pain in shoulder | ☐ | ☐ | Upset stomach- nausea | ☐ Yes | ☐ No |
| Ringing sound in ears (tinnitus) | ☐ | ☐ | Fullness, pressure | ☐ Yes | ☐ No |
| Do you have pain in the ear? | ☐ | ☐ | blockage in ear/congestion | ☐ Yes | ☐ No |
| Pain in forehead | ☐ | ☐ | | | |

## Other Pain Questions

Circle the kind of pain you have: ☐ Sharp ☐ Spreading ☐ Aching ☐ Deep ☐ Dull ☐ Superficial ☐ Pulsating ☐ Burning

Is the pain? ☐ Constant ☐ Intermittent

Does the pain last for ☐ Minutes ☐ Hours ☐ All day

Does the pain start Suddenly? ☐ Gradually

Does the pain stop suddenly ☐ Gradually

What time of the day or night is the pain the most severe

How often do you have pain? ☐ Monthly ☐ Daily ☐ Weekly

What medication(s), if any, do you take to relieve the pain or have you tried?

Does rest increase or decrease the pain?

Please describe any method of positioning the jaw or head that you have found for relieving pain:

Do any of the following normal daily activities cause pain? If yes, indicate where you feel pain.

| | | | |
|---|---|---|---|
| ☐ Yawning | ☐ Swallowing | ☐ Brushing | ☐ Moving shoulders |
| ☐ Chewing | ☐ Speaking | ☐ Moving head | ☐ Moving arms |
| ☐ Singing | ☐ Shouting | ☐ Moving neck | ☐ Moving trunk |

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Patient Name: DOB: DOS:

| DYSFUNCTION | | | | |
|---|---|---|---|---|
| Can you open your mouth normally? | ☐ Completely | ☐ Partially | | |
| Do you ever open so wide your mouth locks open? | | | ☐ Yes | ☐ No |
| Do you have any of these sounds in the joint? | ☐ Snapping | ☐ Grating | | |
| If you have any of these problems is it frequent? | | | ☐ Yes | ☐ No |
| | | | ☐ Yes | ☐ No |

| MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS | | | |
|---|---|---|---|
| Are your jaw muscles ever tired? | | ☐ Yes | ☐ No |
| Have you had any injury to the jaw or face? If yes, explain. | | ☐ Yes | ☐ No |
| Do you attribute the symptoms to any one incident? | | ☐ Yes | ☐ No |
| Have you had cortisone injected into the joint? If yes, when? | | ☐ Yes | ☐ No |
| How many injections? | By whom? | ☐ Yes | ☐ No |
| Do you know if you clench your teeth? | | ☐ Yes | ☐ No |
| Has anyone mentioned that you grind your teeth (brux) at night during sleep? | | ☐ Yes | ☐ No |
| Have you had any other treatment for this problem? (*If yes, explain-medicine, exercise, dental treatment)* | | | |
| Have you had your bite adjusted by your dentist? (*If yes, please explain when)* | | ☐ Yes | ☐ No |
| How long have you been bothered by this problem? | | | |
| Is there anyone else in your family with a similar problem? (*If yes, explain)* | | | |

Please describe briefly any changes in location or character of symptoms since this problem began

Do you chew gum? ☐ Frequently ☐ Moderately ☐ Infrequently ☐ Never ☐