Blanchard Valley Sleep Disorders Center
419.427.2604 • Fax 419.427.2607 • 1909 South Main Street • Findlay, Ohio 45840

SLEEP CENTER MEDICAL HISTORY QUESTIONNAIRE

NAME OF PATIENT: _____

DATE OF BIRTH: _____

MEDICAL HISTORY (Please check all that apply and add additional history that pertains to you now or in the past)

- ❑ Seasonal Allergies
- ❑ Sinusitis
- ❑ Blindness
- ❑ Hearing Loss

- ❑ Hypertension
- ❑ Hypercholesterolemia
- ❑ Coronary Artery Disease
- ❑ Myocardial Infarction (Heart Attack)
- ❑ Atrial Fibrillation
- ❑ Atrial Flutter
- ❑ Ventricular Tachycardia
- ❑ Congestive Heart Failure
- ❑ Heart Valve Disease
- ❑ PAD-Peripheral Artery Disease

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Pulmonary Hypertension
- ❑ Pulmonary Fibrosis
- ❑ Respiratory Failure requiring Oxygen Therapy

- ❑ Arthritis
- ❑ Degenerative Disc Disease
- ❑ Chronic Back Syndrome
- ❑ Muscle Disease

- ❑ Heart Burn (GERD)
- ❑ Peptic Ulcer Disease
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Gastrointestinal Bleeding

- ❑ Chronic Urinary Tract Infections
- ❑ Kidney Stones
- ❑ Benign Prostatic Hypertrophy
- ❑ Interstitial Cystitis
- ❑ Chronic Renal Failure

- ❑ Migraine Headaches
- ❑ Seizure Disorder
- ❑ Neuropathy
- ❑ Stroke
- ❑ TIA
- ❑ Parkinson's Disease
- ❑ Familial (Benign) Tremor
- ❑ Multiple Sclerosis
- ❑ Myasthenia Gravis
- ❑ Muscular Dystrophy
- ❑ Childhood Polio
- ❑ ALS
- ❑ Guillian-Barre Syndrome
- ❑ Cerebral Palsy

- ❑ Chronic Pain
- ❑ Cancer

- ❑ Thyroid Disease
- ❑ Diabetes Mellitus

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- ❑ Insomnia
- ❑ Obstructive Sleep Apnea
- ❑ Narcolepsy
- ❑ Restless Leg Syndrome
- ❑ REM Behavior Disorder
- ❑ Night time eating Disorder
- ❑ Depression
- ❑ Anxiety Disorder
- ❑ Bipolar Mood Disorder
- ❑ ADD
- ❑ ADHD
- ❑ Dyslexia
- ❑ Learning Disability

Other Medical History: _____

_____

_____

SURGICAL HISTORY

Recent	Past	Surgery

FAMILY HISTORY (Check any that apply)

	Heart Disease		Obstructive Sleep Apnea
	Hypertension		Bed wetting
	Diabetes Mellitus		Narcolepsy
	Thyroid Disease		Insomnia
	Lung Disease		Depression
	Colitis		Anxiety
	Kidney Disease		Tuberculosis
	Cancer		Genetic Disease

MEDICATIONS: (SEE LIST)

ALLERGIES: NONE: ❑: _____

_____

_____

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OCCUPATION: _____

Alcohol: NONE: _____ RARE: _____ SOCIAL/WEEKEND: _____ DAILY: _____
"NIGHTCAP": _____ I may use alcohol to help induce sleep: _____

Tobacco: NONE: _____ QUIT: _____ CIGARETTES: _____Packs per day_____# years:_____
CIGARS: _____ CHEW:_____ VAPOR:_____

Caffeine: NONE: _____ COFFEE: _____ TEA:_____ SODA:_____ TABLETS:_____

Exercise: Times per week:_____ Time of Day: AM_____ / PM_____ NONE:_____

REVIEW OF SYSTEM:

General

- ❑ Weight ___Gain, ___Loss
- ❑ Recurring Fever or Chills
- ❑ Fatigue – without clear reason
- ❑ Night Sweats
- ❑ **NONE**

Eyes

- ❑ Corrective Lenses
- ❑ Recent Change in Vision
- ❑ Under the care of an Eye Doctor
- ❑ **NONE**

Ears

- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Hearing Aids
- ❑ Ear Pain
- ❑ **NONE**

Nose/Sinuses

- ❑ Chronic Nasal Congestion
- ❑ Chronic Nasal Drainage
- ❑ Loss of Smell
- ❑ Bleeding from Nose
- ❑ Chronic Sinusitis
- ❑ **NONE**

Throat

- ❑ Recurrent sore throats or Tonsillitis
- ❑ Difficulty Swallowing
- ❑ Coughing after swallowing
- ❑ Vocal Hoarseness
- ❑ **NONE**

Cardiovascular

- ❑ Chest Pain
- ❑ Palpitations
- ❑ History of Heart Murmur
- ❑ Leg or ankle swelling (edema)
- ❑ Pain in legs with walking
- ❑ Cold Hands or Feet
- ❑ **NONE**

Respiratory

- ❑ Shortness of Breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sputum Production
- ❑ Coughing Up Blood
- ❑ **NONE**

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Gastrointestinal

Appetite: Good____ Fair____ Poor_____

- ❑ Gastroesophageal Reflux (GERD)
- ❑ Wake up Hungry at Night
- ❑ Get up at Night to Eat
- ❑ Change in Bowel Habits
- ❑ Blood in Bowel Movements
- ❑ **NONE**

Genitourinary

- ❑ Get up at Night to Urinate
- ❑ Urgent Urination
- ❑ Painful Urination
- ❑ Blood in Urination
- ❑ Less than perfect Bladder control
- ❑ **NONE**

Musculoskeletal

- ❑ Joint pain, stiffness or swelling
- ❑ Muscle pain
- ❑ Chronic back pain
- ❑ Require an appliance (cane/walker/wheelchair/scooter)
- ❑ **NONE**

Neurologic

- ❑ Recurring Headaches
- ❑ History of Seizure
- ❑ Numbness, Tingling
- ❑ Chronic Pain
- ❑ Restless Legs
- ❑ Tremors
- ❑ Muscle Weakness
- ❑ **NONE**

Skin

- ❑ Chronic Rash
- ❑ Itchy Dry Skin
- ❑ Suspicious Lesions
- ❑ History of Cellulitis
- ❑ **NONE**

Endocrine

- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Coarse Hair with Dry Skin
- ❑ Increase Thirst
- ❑ Excessive Urination
- ❑ **NONE**

Psychiatric

- ❑ Depression
- ❑ Anxiety
- ❑ Less than perfect Memory
- ❑ Thoughts of suicide
- ❑ Fear – people, places, circumstances
- ❑ **NONE**

Hematologic/Lymphatic

- ❑ Bruising
- ❑ Anemia or Iron Deficiency
- ❑ Enlarged Lymph Nodes
- ❑ **NONE**

Immunologic

- ❑ Poorly healing wound
- ❑ Recurrent or persistent Infection
- ❑ HIV Exposure
- ❑ History of Hepatitis B or C
- ❑ **NONE**

DATE _____/_____/_____

_____

Patient Signature

_____

Provider Signature

Date: ____/____/____ Time: _____/_____