Dedicated Sleep

COMPREHENSIVE HEALTH QUESTIONNAIRE

FLORIDA DENTAL SLEEP DISORDERS

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:

Medical History

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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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	O:onstant
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)	D Day		D Evening		☐ Night

Slee13 Questions	Never	Rarely	Often	Fre(luent	Always
How often do you rotate shifts?	D	☐	☐	☐	☐
Does your job require overnight travel?	D	☐	☐	☐	☐
Do you drink alcohol after 6pm?	D	☐	☐	☐	☐
Do you drink caffeinated beverages after 6pm?	D	☐	☐	☐	☐
Do you suffer from a loss of libido?	D	☐	☐	☐	☐
(Males) Have you experienced difficulties with sexual functions?	D	☐	☐	☐	☐

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Sleer, Questions	Never	Rarely	Often	Fre(luent	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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Do you wake up with sore or aching muscles or joints (including leg or back pain)?	☐	☐	☐	☐	☐
Do you grind or clench your teeth during sleep?	☐	☐	☐	☐	☐
Did you walk or talk in your sleep as a child or adolescent?	☐	☐	☐	☐	☐
Do you now walk or talk in your sleep?	☐	☐	☐	☐	☐
Do you have frightening dreams or nightmares?	☐	☐	☐	☐	☐
Do your dreams or nightmares awaken you?	☐	☐	☐	☐	☐
Do you wet your bed?	☐	☐	☐	☐	☐

Other Sleep Concerns: