Name: DOB: Date form completed:

Sleep Disorders Questionnaire

1. Who encouraged you to get a sleep disorders evaluation?
(e.g. spouse, friend, doctor (doctor's name), hospital experience, your own concerns)

____

2. What do you hope to achieve from this consultation?

____

____

3. What do you do during the hour or so before turning out the lights (circle)?
e.g. TV/streaming video, listen to music, reading, internet browsing, email, work

____

4. What part of your home are you usually in during this pre-bedtime activity?

____

5. Do you use cigarettes, marijuana, nicotine products, alcohol, other drugs near bedtime?
☐Yes (explain) ☐No ______________________________

6. Do you use or have you tried any **prescription** *or* **over-the-counter sleep aids**?
Current sleep aids: ______________________________
How well are they working on a 1-10 scale, 1 = not at all, 10 = extremely helpful _____
Comments:______________________________

Past sleep aids tried: ______________________________

7. What time do you usually **close your eyes and try to fall asleep?**
a. Weekdays/work or school days ____________________
b. Weekends/days off ____________________

8. How long does it usually take to initially fall asleep **after you first turn off lights & try to go to sleep**? (give a range) ____________________

9. How often do you wake up at night (range)? ____________________

10. Why do you wake up at night? ☐bathroom • ☐snoring • ☐trouble breathing
☐choking feeling • ☐acid reflux or heartburn • ☐anxiety/worry • ☐palpitations
☐leg pain/discomfort • ☐jumpy legs • ☐ restless legs • ☐pain (where) ____________
other (explain) ______________________________

11. Do you frequently eat/snack when you wake up at night? ☐Yes ☐No

12. If you wake at night, is it often difficult to get back to sleep? ☐Yes (explain) ☐No

13. What time do you get up for **work or school** (if applicable)? ____________________
How much total sleep do you think you get most **work/school nights?** __________

14. What time do you get up on **weekends or non-work days**? ____________________
How much total sleep do you think you get most **weekend or days off?** __________

15. Do you use an **alarm clock or clock radio** to help you wake up?
☐No ☐most or every day ☐work/school days only

16. Most days I wake up feeling:
☐Full of energy and wide awake
☐Somewhat rested, could probably use more sleep
☐Still tired or sleepy

17. Do you take **naps** during the day?
a. ☐Never • ☐1-2x weekly • ☐3-4x weekly • ☐5-6x weekly • ☐everyday
b. How long do you usually nap?______________________________
c. Do you wake up from your naps rested/refreshed? ☐Yes • ☐No • ☐Somewhat

18. Do you **fall asleep unintentionally** during the day?
(e.g. work, meetings, school, reading, driving, TV etc)
☐Never • ☐Occasionally • ☐Most days
Examples: ______________________________

19. Do you **frequently** get **sleepy or drowsy while driving**?
☐Yes • ☐No • ☐I do not drive

20. Do you often let someone else drive because of sleepiness or fatigue? ☐Yes • ☐No

21. Over past five years have you had any motor vehicle accidents or "near-misses" while driving due to sleepiness, drowsiness or fatigue? ☐Yes • ☐No
Details if yes: ______________________________

22. Do you have difficulty with ☐**Short term memory** ☐**Focus/concentration**

23. When you try to relax in the evening or at bedtime, do you ever have **unpleasant, restless feelings in your legs, arms** or **body** (*other than muscle cramps*) that can be relieved by movement (e.g. stretching or massaging legs, pounding legs, walking)?
☐Never • ☐1-3 times per/month • ☐1-3x/week • ☐Most days

Describe the feeling:______________________________
How old were you when the unpleasant restless feelings started? _______

24. Have you been told or noticed that your arms/legs jump or twitch when you sleep?
☐Never • ☐Occasionally • ☐Most nights

25. Do you experience **muscle cramps in your legs at night**?
☐Never • ☐Occasionally • ☐Most nights

26. Are you a **restless sleeper**? ☐Yes • ☐No
(change positions a lot, toss and turn, wake up with bed sheets and blankets out of place)

27. What position(s) do you sleep in?

☐back • ☐left side • ☐right side • ☐stomach • ☐chair • ☐hospital-type bed

28. Do you **snore** loud enough to **wake yourself up or disturb others**?
☐Never • ☐Occasionally • ☐Most nights • ☐Only sleeping on my back

29. Have you been told that you **hold your breath** *or* **stop breathing while you sleep**? ☐Yes • ☐No Explain: ______________________________

____

30. Do you wake up with a **choking feeling** at night?
☐Never • ☐Occasionally • ☐Frequently

31. Do you wake up with **heartburn or acid reflux**?
☐Never • ☐Occasionally • ☐Frequently

32. Do you **wake up from sleep** feeling **short of breath** or **gasping for air**?
☐Never • ☐Occasionally • ☐Frequently

33. Do you <u>frequently</u> wake up with a **dry mouth**? ☐Yes • ☐No

34. Do you **wake up with a headache**?

☐Never • ☐1-3x/month • ☐1-3x/week • ☐Most days

35. Do you grind your teeth or clench at night? ☐**Grind** • ☐**Clench** • ☐Neither

36. Do you or have you used a **Nite (Bite) Guard** to protect your teeth? ☐Yes • ☐No

37. Do you get up to **urinate at night**? ☐Yes • ☐No How often? ___________________

38. Do you tend to **sweat heavily at night**? ☐Never • ☐Occasionally • ☐Most nights

39. Have you ever woken up feeling like you were ***acting out a dream***, e.g. **kicking, punching, jumping out of bed in response to your dream**? ☐ Yes • ☐ No

40. Do you **sleepwalk** <u>in past five years</u>? ☐Yes • ☐No
Details if yes:____

41. Have you had a **seizure (convulsion, epilepsy) while sleeping** *in past five years*?
☐Yes • ☐No
If yes, describe what happened? ________________________________

____

42. Did you ever drive your car somewhere, then not remember driving there?
☐Yes • ☐No

43. Do you ever **fall asleep suddenly during the day**, without feeling sleepy a few minutes earlier? ☐Never • ☐Occasionally • ☐Frequently

44. How often do you **dream at night**? ☐Never • ☐Occasionally • ☐Most nights

45. Do you experience **dreams during daytime naps**? ☐Never • ☐Occasionally • ☐Often

46. Have you ever woken up feeling completely aware & alert, able to hear your surroundings, but unable to move your body? ☐Yes • ☐No

47. Have you ever felt like you:

a. started to dream before falling asleep ☐Yes • ☐No
b. were still experiencing a dream after you woke up ☐Yes • ☐No

48. Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following situations?

a. When you laugh, e.g. get "weak knees" ☐Yes • ☐No
b. When you are angry ☐Yes • ☐No
c. When hearing or telling a joke ☐Yes • ☐No

49. Do you frequently travel across 2 or more time zones? ☐Yes • ☐No

50. Do you or those who know you consider you a

a. "**night owl**" ☐Yes • ☐No • ☐Somewhat
b. "**morning person**" ☐Yes • ☐No • ☐Somewhat

51. Do you worry or experience **anxiety about your sleep**?
☐Never • ☐Occasionally • ☐Most nights

52. **<u>Over past few months</u>**, how often do you experience these issues

a. At bedtime, **thoughts race through my mind**
☐Never • ☐Occasionally • ☐Most nights

b. At bedtime, **I worry about things**
☐Never • ☐Occasionally • ☐Most nights

c. At bedtime, **I'm afraid of not being able to go to sleep**
☐Never • ☐Occasionally • ☐Most nights

d. **After waking up at night**, **I'm afraid I will not get back to sleep**
☐Never • ☐Occasionally • ☐Most nights

e. **I sleep better in unfamiliar places such as a hotel room**
☐Never • ☐Occasionally • ☐Most nights

Name: DOB: Date form completed:

53. Insomnia Severity Index

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
A. Difficulty falling asleep	☐ 0	☐1	☐ 2	☐ 3	☐ 4
B. Difficulty staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C. Problems waking up too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

D. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

E. How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

F. How **WORRIED/DISTRESSED** are you about your current sleep pattern?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

G. To what extent do you consider your sleep problem to **INTERFERE** with you daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory) CURRENTLY?

Not at all	A little	Somewhat	Much	Very Much
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

54. Epworth Sleepiness Score

How likely are you to doze or fall asleep in the situations described below, 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

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing			
	Never	Slight	Moderate	High
Sitting and reading	☐ 0	☐1	☐ 2	☐ 3
Watching TV	☐ 0	☐1	☐ 2	☐ 3
Sitting, inactive in a public place (e.g. a theater or a meeting)	☐ 0	☐1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐1	☐ 2	☐ 3

Name: DOB: Date form completed:

55. The Fatigue Severity Scale (FSS) is a method of evaluation the impact of fatigue on you.
The FSS is a short questionnaire that requires you to rate your level of fatigue.
The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

A low value (e.g. 1) indicates strong disagreement with the statement, whereas a high value (e.g. 7) indicates strong agreement.

Pick a number (1 to 7) for every question even if you have to guess.

During the past week, I have found that:	**Disagree ←-----------------------→Agree**						
My motivation is lower when I am fatigued.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Exercise brings on my fatigue.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
I am easily fatigued.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with my physical functioning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue causes frequent problems for me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
My fatigue prevents sustained physical functioning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with carrying out certain duties and responsibilities.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue is among my three most disabling symptoms.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Fatigue interferes with my work, family, or social life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Total score:						

Name: DOB: Date form completed:

56. Over the past 2 weeks, how often have you been bothered by any of the following?

	Not At all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying	☐	☐	☐	☐
c. Little interest or pleasure in doing things?	☐	☐	☐	☐
d. Feeling down, depressed or hopeless?	☐	☐	☐	☐

57. Over the past month, how much of a problem were the following conditions for you?

	None	Very mild	Moderate	Fairly bad	Severe
a. Nasal congestion or stuffiness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
b. Nasal blockage or obstruction	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
c. Trouble breathing thru nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
d. Unable to get enough air thru my nose during exertion or exercise	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
e. Trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

58. Past testing and treatment for sleep problems

☐ past evaluation with a sleep specialist; if so where/who with? ____________________

____

☐ past sleep study at home; if so with what doctor or company? ____________________

☐ past sleep study overnight at a sleep testing facility; if so where? ________________

____

☐ past or current use of **CPAP or bilevel PAP** machine at home

☐ past **surgical treatment for sleep apnea**

☐ past or current use of a **dental appliance to treat sleep apnea**

☐ past or current treatment for **restless legs**

☐ past or current treatment for **REM sleep behavior disorder (acting out your dreams)**

☐ past or current **non-medication** treatments for insomnia, e.g. behavioral therapy, hypnosis

____

☐ any other past evaluation or treatment for sleep problems

59. Check any of these childhood diseases you recall having:

☐ whooping cough
☐ polio
☐ rheumatic fever
☐ chicken pox

60. Check any of these medical problems you have now or in the past?

☐ narcolepsy
☐ sleep apnea
☐ TMJ disorder
☐ braces/orthodontics
☐ dentures
☐ loose/missing teeth
☐ Restless legs
☐ Iron-deficiency
☐ Anemia
☐ Bipolar disorder
☐ Depression
☐ Anxiety disorder
☐ Schizophrenia
☐ Chronic fatigue
☐ head injury/concussion
☐ Frequent headaches
☐ Migraines
☐ Fibromyalgia
☐ Other persistent pain
☐ Where? __________
____
☐ Osteoarthritis
☐ Gout
☐ Rheumatoid arthritis
☐ Scleroderma
☐ Lupus

☐ GERD/acid reflux
☐ Nose sinus allergies
☐ Allergy shots
☐ Eczema
☐ Asthma
☐ COPD/emphysema
☐ Chronic bronchitis
☐ pulmonary fibrosis
☐ Sarcoidosis
☐ Valley fever (Cocci)
☐ Asbestos lung disease
☐ tuberculosis
☐ other lung disease
____
____
☐ HIV infection
☐ Enlarged prostate
☐ Bladder problems
☐ Parkinson's
☐ Seizures/epilepsy
☐ Dementia
☐ macular degeneration
☐ glaucoma
☐ cataracts

☐ Alcohol abuse
☐ Cocaine use
☐ Methamphetamine use
☐ Other drug abuse
____
☐ High blood pressure
☐ Cholesterol/lipid problems
☐ Diabetes
☐ Atrial fibrillation or flutter
☐ Heart rhythm problem
☐ Heart attack
☐ Stroke
☐ TIA
☐ Congestive heart failure
☐ pulmonary hypertension
☐ Blood clots in leg
☐ Blood clots in lung
☐ Underactive thyroid
☐ Goiter
☐ Kidney disease
☐ Kidney stones
☐ Gallstones
☐ Liver disease
☐ Ulcerative colitis
☐ Crohn's disease

61. Have you had a **tuberculosis test** (skin test "PPD", or blood test "Quantiferon Gold"):

Quantiferon Gold	☐ not done	Year:	☐ normal	☐ abnormal
PPD (TB skin test)	☐ not done	Year:	☐ normal	☐ abnormal

Have you ever received any **treatment for tuberculosis**? ☐ Yes • ☐ No

62. List any forms of **cancer/malignancy** you have or had in past: ____________________

____

63. Other major non-surgical problems not listed above (*list surgery on next page*)

____

Name: DOB: Date form completed:

64. Check or list all **surgery/medical procedures** you remember having:

☐ tonsils removed	☐ adenoids removed	☐ Sinus surgery
☐ nasal septum repaired	☐ soft palate/uvula	☐ tongue surgery
☐ jaw surgery	☐ heart bypass	☐ heart valve replaced
☐ heart stent or angioplasty	☐ other stent or angioplasty	☐ pacemaker ***or*** defibrillator
☐ gallbladder removed	☐ lung surgery	☐ ulcer surgery
☐ gastric bypass	☐ gastric lap band	☐ gastric sleeve
☐ surgery for GERD/acid reflux	☐ appendix removed	☐ hysterectomy
☐ hip replacement	☐ knee replacement	☐ prostate surgery
☐ cataract surgery	☐ retinal surgery	☐ glaucoma surgery

Other surgery/procedures: ____

____

65. List all prescription medications you take including asthma inhalers, nasal sprays, topical medications and as needed medications (*OR ATTACH A LIST OF YOUR MEDICATIONS*):

Medicine	**Dose/strength**	**When/how often you take it**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

66. List all **over-the-counter medicine** you take, e.g. vitamins, minerals, supplements, herbals

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Name: DOB: Date form completed:

67. List any **medications** you are **allergic to, sensitive to** or **react badly to**:

Name of Medicine	**Type of reaction** (e.g. hives, swollen tongue, breathing)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

68. Have you had **x-ray test where dye (contrast) was injected into your blood?**

☐Yes ☐No

If yes, describe any side effects or allergic reaction to the dye: ______________________

____

69. Have you ever received **chemotherapy** ☐Yes ☐No **radiation therapy**? ☐Yes ☐No

Provide details? ____

70. Have you ever **donated blood**? ☐Yes ☐No When? _____________

71. Have you ever received a **blood transfusion**? ☐Yes ☐No When? _____________

72. Do you think you might be **at risk for HIV infection or AIDS**? ☐Yes ☐No

73. Have you been **exposed to any of these**?

☐ exotic birds or bird feathers currently ☐ grain dust ☐ moldy hay

☐ hot tub/spa at home currently ☐ asbestos ☐ beryllium

☐ sandblasting ☐ welding ☐ heavy metals

☐ pesticides ☐solder ☐ baking flour dust

☐ other (explain) ____

74. Home relationships:

a. ☐married/long-term relationship ☐never married ☐widowed ☐separated ☐divorced

b. ☐my spouse/significant other sleeps in a separate bed or separate bedroom

75. Who lives at home with you? ______________________________

76. Where did you grow up? ______________________________

How long have you lived locally? ______________________________

Where else have you lived and when? ______________________________

____

77. What is your highest level of school attended? ______________________________

78. Current employment status?

☐self-employed ☐employee ☐unemployed ☐retired ☐disabled

79. What is your current or most recent occupation? ______________________________

80. What other type of work have you done in the past? ______________________________

____

81. Describe any military experience? ______________________________

82. List travel outside the United States in the past 5 years ______________________________

83. Describe your diet: ______________________________

84. Describe your usual exercise: ______________________________

85. Do you currently smoke: ☐vape or E-cigarettes ☐cigarettes ☐cigars ☐pipe ☐marijuana

How much do you smoke? ______________________________

86. If you quit smoking, describe your past smoking habits: ***how much & how long***?

____

☐ I never smoked

87. How *often* do you have a drink containing alcohol?

☐ I never drank alcohol in my life
☐ Never
☐ Monthly or less
☐ 2-4x/month
☐ 2-3x/week
☐ 4 or more times/week

88. How many standard drinks containing alcohol do you have on a *typical day*?

☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-9
☐ 10 or more

89. How often do you have six or more drinks *on one occasion*?

☐ Never
☐ less than monthly
☐ 2-4x/month
☐ 2-3x/week
☐ 4 or more times/week

90. Do you drink any **caffeinated beverages**?

☐ **coffee** How much? ______________________________
☐ **tea** How much? ______________________________
☐ **cola/mountain dew** How much? ______________________________
☐ **energy drinks** How much? ______________________________
Latest time of day you usually consume caffeine? ____________________

91. List any **pets/animals at home**, including birds, rodents, reptiles, farm/ranch animals

____

____

Name: DOB: Date form completed:

92. List family members with the following problems:

sleep apnea **loud snoring**	**restless legs**
narcolepsy	**long-term insomnia**
sleep walking	
depression	**anxiety disorder**
high blood pressure	**diabetes**
high cholesterol or triglycerides	**heart attack or clogged arteries**
congestive heart failure	**stroke**
asthma	**nasal allergies**, e.g. pollen, dust, cat
blood clots in legs or lung	Other:
dementia or Alzheimer's	**Parkinson's**

93.Complete the following about your family medical history:

☐ I am adopted and don't know anything about my biological family medical problems

Relative	Age	Alive?	Cause of death	Major health problems
Father				
Mother				

Complete for ***brothers, sisters, sons, daughters*** *– please* ***list them even if healthy***

Relative	Age	Alive?	Cause of death	Major health problems

Name: DOB: Date form completed:

94. Review of Systems

How tall are you? __________

- Have you lost height due to osteoporosis or other reasons? ☐Yes ☐No
- If so, how much height have you lost? ______

What is your neck/collar size (if known)? ______
What is your most recent weight? ______
Estimate your weight 1 year ago? ______
Estimate your weight 5 years ago? ______
Estimate your weight 10 years ago? ______
Estimate your weight at age 21? ______

Have you experienced any of these *within past month*?

Yes	No	Constitutional
☐Y	☐N	loss of appetite
☐Y	☐N	weight loss
☐Y	☐N	weight gain
☐Y	☐N	chills or fevers
☐Y	☐N	heavy sweating at night
☐Y	☐N	fatigued/tired

Yes	No	Eye
☐Y	☐N	recent change in vision
☐Y	☐N	itchy eyes
☐Y	☐N	watery eyes
☐Y	☐N	dry eyes
☐Y	☐N	eye pain

Yes	No	ENT
☐Y	☐N	hearing loss
☐Y	☐N	ringing in ears
☐Y	☐N	impaired smell
☐Y	☐N	impaired taste
☐Y	☐N	frequent bad breath
☐Y	☐N	recurring nose bleeds
☐Y	☐N	sneezing
☐Y	☐N	nasal congestion
☐Y	☐N	nasal spray (e.g. Afrin, 4-way, Dristan)
☐Y	☐N	post-nasal drip
☐Y	☐N	frequently clear throat
☐Y	☐N	hoarse voice
☐Y	☐N	sore throat

Yes	No	Cardiovascular
☐Y	☐N	chest pain or pressure
☐Y	☐N	palpitations
☐Y	☐N	rapid heart beat

Yes	No	Respiratory
☐Y	☐N	cough
☐Y	☐N	sputum production
☐Y	☐N	coughing up blood
☐Y	☐N	trouble breathing with exertion
☐Y	☐N	trouble breathing lying down
☐Y	☐N	waking up at night with difficulty breathing
☐Y	☐N	wheezing
☐Y	☐N	chest tightness

Yes	No	Gastrointestinal
☐Y	☐N	nausea or vomiting
☐Y	☐N	difficulty swallowing
☐Y	☐N	pain when swallowing
☐Y	☐N	acid reflux
☐Y	☐N	heart burn
☐Y	☐N	bloated feeling
☐Y	☐N	excessive burping
☐Y	☐N	passing excessive gas

Name: DOB: Date form completed:

Have you experienced any of these *within past month*?

Yes	No	Musculoskeletal
☐Y	☐N	muscle pain
Where?_______________________________		
☐Y	☐N	leg cramps at night
☐Y	☐N	joint pain
	Where? _________	
☐Y	☐N	joint stiffness
	Where? _________	

Yes	No	Skin
☐Y	☐N	current skin rash
☐Y	☐N	frequent itching
☐Y	☐N	current skin cancer
☐Y	☐N	other skin problem
Explain: ______________________________		

Yes	No	Neurologic
☐Y	☐N	frequent headaches
☐Y	☐N	recent seizure
☐Y	☐N	recent stroke
☐Y	☐N	difficulty walking
☐Y	☐N	difficulty speaking
☐Y	☐N	memory loss
☐Y	☐N	hand tremor
☐Y	☐N	sensation of room spinning

Yes	No	Psychologic
☐Y	☐N	depression
☐Y	☐N	anxiety/nervousness
☐Y	☐N	hallucinations
☐Y	☐N	paranoid thoughts
☐Y	☐N	claustrophobia

Yes	No	Endocrine
☐Y	☐N	poor tolerance of cold
☐Y	☐N	poor tolerance of heat
☐Y	☐N	extreme thirst
☐Y	☐N	loss of interest in sex
☐Y	☐N	poor sexual function

Yes	No	Heme & Lymphatic
☐Y	☐N	anemia (low red cells)
☐Y	☐N	iron deficiency
☐Y	☐N	swollen glands:
	Where? _______	
☐Y	☐N	easy bleeding
☐Y	☐N	easy bruising

Yes	No	Allergic & Immunologic
☐Y	☐N	immune deficiency:
Explain: ___________________________________		
☐Y	☐N	autoimmune disorder
Explain: ___________________________________		

Yes	No	Genitourinary system
☐Y	☐N	difficult-slow urination
☐Y	☐N	urinate at night?
How often? ________________________________		
☐Y	☐N	poor bladder control

Women only

How many pregnancies? ____________

How many miscarriages? ___________

Are you still menstruating? __________

Age at time of menopause? _________

Unusually prolonged or heavy bleeding?
☐ yes ☐ no

Hysterectomy
☐ yes ☐ no

Age at time of hysterectomy _____