Mercy Memorial Health Center
Sleep Disorder Services
Medicare Medical History and Sleep Questionnaire

Name:_____**Date**_____

Physician:_____**Ht:**_____**Wt:**_____

1. Briefly describe the nature of your sleep problem:_____
   _____
   _____
   _____

2.	Do you snore?	Yes	No
3.	Have you been told that it appears your breathing stops during your sleep?	Yes	No
4.	Do you toss and turn frequently during your sleep?	Yes	No
5.	Do you sweat excessively during your sleep?	Yes	No
6.	Do you awaken from sleep with a headache?	Yes	No
7.	Do you suffer from high blood pressure?	Yes	No
8.	Do you have difficulty falling asleep?	Yes	No
9.	Do you experience vivid dream-like images when falling asleep or waking up?	Yes	No
10.	Do you have muscle weakness or have you collapsed from feeling strong emotions such as anger or surprise?	Yes	No
11.	Are you sometimes unable to move when waking up or falling asleep?	Yes	No
12.	Do you wake up early during the night then have a difficult time getting back to sleep?	Yes	No
13.	Do you experience creeping sensations in your legs at night and feel as though you must move them?	Yes	No
14.	Do you kick your legs or jerk during your sleep?	Yes	No
15.	Is your bedding in a mess when you wake up?	Yes	No
16.	Do you wake up during the night or in the morning with heart burn?	Yes	No

17. Do you smoke? Yes No If yes, how many packs a day?_____

18. Do you drink alcohol? Yes No If yes, how many glasses a day?____

19. Do you drink caffeine? Yes No If yes, how much a day?_____
Do you drink Soda_____ Tea_____ Coffee_____

20. What time do you normally go to bed?_____Wake up?_____

21. Please list any serious illnesses or major surgery you have experienced and the date.

Illness/surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

22. Please list all medications you are currently taking, include the dosage.

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____