COOKEVILLE REGIONAL
MEDICAL CENTER
SLEEP CENTER

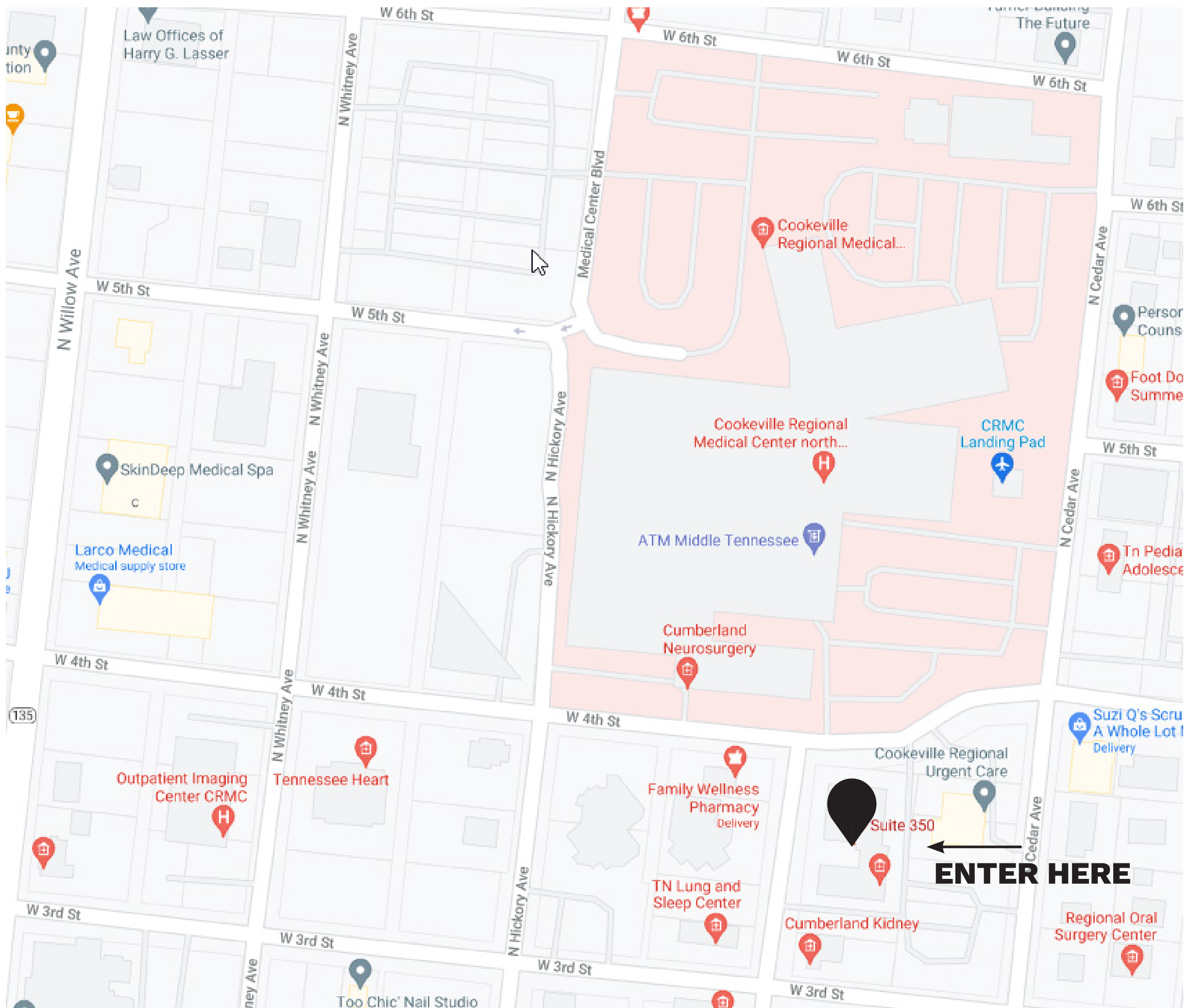
100 West Fourth Street, Suite 350
Cookeville, TN 38501
(931) 783-2753 • Fax: (931) 783-2036

Patient Name:____ HST/AST/CLINIC

Appointment Date: ____________________________Time: ________________ AM / PM

Please bring with you a current Medication List along with any Medical Records that you think we may need to look at when reviewing your medical history. (Example if you have had a sleep study before please bring a copy if possible.) Please bring insurance cards and a i.d. Thank you!*

We are located at 100 W 4th Street Suite 350. We are at the back of the Upper Cumberland Ear Nose & Throat building, the same entrance as the Allergy, Asthma and Sinus Center. You can enter our parking lot for Cedar Avenue. Take the elevator to the 3rd floor.



Date: ____

NAME:
First: ____________________ Middle: __________________ Last: ____________________

SSN: (for insurance purposes) ________ - _________ - __________

Date of Birth: _____ / _______/ ______ Age: ________ SEX: ❑ Male ❑ Female

Address: ____

____

Phone: Home: ( ) _____ - ___________ Cell: ( ) _____ - ___________

Primary Doctor: ____

Referring Doctor: ____

Occupation: ____

Please check: ❑ Retired ❑ Disabled ❑ Active in Employment ❑ Unemployed

Employer: ____

Employer Address: ____

____

Phone: Home: ( ) _____ - ___________

FOR INSURANCE PURPOSES:

Spouse / Responsible Party *Name:* ____

Spouse / Responsible Party *Date of Birth:* _______ / ______ / ________

Spouse / Responsible Party *SSN* (for insurance purposes) _______ - ________ - ________

Phone: Home: ( ) _____ - ___________ Cell: ( ) _____ - ___________

THE SLEEP CENTER AT COOKEVILLE REGIONAL MEDICAL CENTER

MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ SEX: __________ DATE: ______________

DOB: ______________ AGE: ______ Primary Doctor / Care Manager: ______________________

HEIGHT: ______________ WEIGHT: ______________ HEAVIEST WEIGHT: ______________

Chief sleep related complaint: ____

Have you ever had a sleep study before? __________ When? __________ Where? ______________

USE THIS SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

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

______ Sitting and reading

______ Watching TV

______ Sitting in a public place for example, a theatre or meeting

______ As a passenger in a car for an hour without a break

______ Lying down to rest in the afternoon

______ Sitting and talking to someone

______ Sitting quietly after lunch (when you have had no alcohol)

______ In a car, while stopped in traffic

CHECK ALL THAT APPLY

☐ **Snoring** ☐ Mild ☐ Moderate ☐ Loud ☐ On my back ☐ All positions

☐ **I wake up** ☐ Choking ☐ Coughing ☐ Gasping ☐ Smothering ☐ Snoring ☐ Sweating

☐ **Told I stop breathing in my sleep**

☐ **I disturb my bed partner**

☐ **Get up to go to the bathroom** ☐ O ☐ 1 ☐ 2 ☐ 3 ☐ Multiple **times each night**

☐ **Heart** ☐ Racing ☐ Pounding ☐ Palpitations at night

☐ **Restless sleep**

☐ **Morning dry mouth**

☐ **Morning headaches**

☐ **I wake up feeling** ☐ Refreshed ☐ Tired

☐ **During the day, I feel** ☐ Tired ☐ Fatigued ☐ Sleepy ☐ Exhausted

☐ **I have trouble staying awake** ☐ Driving ☐ Work ☐ Meetings ☐ Reading ☐ Watching TV

☐ **I have had motor vehicle accidents due to sleepy driving**

☐ **I struggle with** ☐ Memory ☐ Attention ☐ Concentration ☐ Judgment ☐ Motivation

☐ **I drink** ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Drinks

☐ **I nap** ☐ Daily ☐ Weekends ________ times per week How long do naps last? ______________

How long have you had these symptoms? ____

CHECK ALL THAT APPLY

What time do you get into bed? Workdays___________ Non-Workdays ____________

What time do you get out of the bed? Workdays___________ Non-Workdays ____________

What is your typical sleeping position? ☐ Back ☐ Side ☐ Stomach ☐ Recliner ☐ Couch

How many hours do you sleep on the average night? _______________________________

With whom do you share the bedroom? ☐ Spouse ☐ Partner ☐ Children ☐ Pets

PRE-SLEEP ROUTINE (CHECK ALL THAT APPLY)

☐ **I watch TV** ☐ In the bedroom ☐ In another room ☐ Both

☐ **The TV is on all night**

☐ **I read** ☐ In the bedroom ☐ In another room ☐ Both

☐ **I spend time on the computer / phone**

☐ **I play video games**

☐ **I spend time on work or studying**

☐ **I exercise within 3 hours of bed**

☐ **I shower or bathe**

INS (CHECK ALL THAT APPLY)

☐ **I have trouble falling asleep**

☐ **I have trouble staying asleep**

☐ **I wake up early in the morning and can't go back to sleep**

☐ **I worry about being unable to fall asleep**

☐ **Thoughts are racing through my mind when I try to go to sleep**

☐ **I watch the alarm clock at night**

Have you ever seen a psychologist for treatment of insomnia? ______________________________________

MOV (CHECK ALL THAT APPLY)

☐ **Before sleep, I have an urge to move my legs or arms**

☐ **These symptoms start or get worse at night or in the evening**

☐ **My legs or arms continue to move or jerk during sleep.**

☐ **I have a history of iron deficiency or anemia**

☐ **Just as I am falling asleep, my muscles jerk**

☐ **I grind or clench my teeth during sleep**

☐ **I wear a mouth guard**

BEH (CHECK ALL THAT APPLY)

☐ **Sleepwalking** ☐ Childhood ☐ Currently

☐ **I get up to eat during sleep, and I don't remember doing it.**

☐ **I talk in my sleep**

☐ **I suddenly rouse from sleep with panic and confusion**

☐ **I have bad dreams or nightmares**

☐ **I have hurt myself or my bed partner during sleep** _________

NAR AND HYPERSOM (CHECK ALL THAT APPLY)

☐ **I have sleep attacks where I fall asleep without warning or against my will**

☐ **When struck by a sudden emotion** ☐ Laughter ☐ Excitement ☐ Anxiety **my muscles become weak.**

☐ I drop things ☐ I collapse ☐ I get weak in the knees ☐ My face feels weak ☐ My hands feel weak

☐ I have trouble talking ☐ I lean against the wall ☐ I sit down

☐ **I feel paralyzed or unable to move when falling asleep or when waking up.**

☐ **I visually hallucinate or see things in the room when I am falling asleep or when I wake from sleep.**

MEDICATIONS THAT YOU HAVE PREVIOUSLY TRIED FOR SLEEP (CHECK ALL THAT APPLY)

☐ Ambien/zolpidem
☐ Benadryl
☐ Desyrel/trazodone
☐ Elavil/amitriptyline
☐ Lunesta/eszopidone
☐ Melatonin
☐ Remeron/mirtazepine
☐ Restoril/temazepam
☐ Rozerem/Ramelteon
☐ Seroquel/quetiapine
☐ Silenor/Doxepin
☐ Sonata/zaleplon
☐ Surorevant/Belsomra
☐ Tylenol Pm

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS OR PROVIDE LIST:

Pharmacy: ____________________

NAME of Medication	DOSE	FREQUENCY

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐ Acid Reflux / Heartburn
☐ ADD/ADHD
☐ (Alcohol) (Drug) (Medication) Addiction
☐ Anemia
☐ Anxiety Disorder
☐ Arrhythmia (Atrial Fibrillation)
☐ Arthritis
☐ Asthma (childhood) (Current)
☐ Bipolar Disorder
☐ Cancer (Type:____________________)
☐ COPD / Emphysema
☐ COVID-19 Infection
☐ Colon Disease / Hemorrhoids
☐ Depression
☐ Diabetes
☐ Epilepsy / Seizures
☐ Fibromyalgia
☐ Head Injury / TBI
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Menopause
☐ Migraine
☐ Nasal Allergies (seasonal) (all year)
☐ Neuropathy
☐ Pain [chronic]
☐ Post Traumatic Stress Disorder
☐ Pregnancy
☐ Prostate Disease
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ TIA
☐ Additional

____
____
____
____

What Drugs are you allergic to:

____________________ ____________________
____________________ ____________________

PAST SURGICAL HISTORY (CHECK ALL THAT APPLY)

☐ Weight loss surgery ☐ Tonsillectomy

☐ Sinus Surgery ☐ Septoplasty

ADDITIONAL SURGERIES

FAMILY HISTORY (CHECK ALL THAT APPLY)

Members	Living or Deceased	Sleep Apnea	Insomnia	Restless Legs	Narcolepsy	Sleep Walking	High Blood Pressure	Stroke	Heart Disease	Diabetes
Father										
Mother										
Brother(s)										
Sister(s)										
Son(s)										
Daughter(s)										

Other significant family history: ______

SOCIAL HISTORY

Do you use tobacco products now? ☐ **Yes** ☐ **No** **In the past?** ☐ **Yes** ☐ **No**

☐ Cigarettes ☐ Electronic Nicotine ☐ Smokeless (dip/chew/snuff)

How much? ______ How long? ______ When did you quit? ______

☐ **I drink alcohol** ☐ Beer ☐ Wine ☐ Liquor ☐ Every Night ☐ ______ Nights per week

How much? ______

Do you have a history of drug use? ☐ **Yes** ☐ **No**

What? ______

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time

What is / was your occupation? ______

☐ My job requires me to drive

☐ Shift work ☐ permanent night shift ☐ rotating shift Which shift ______

☐ I am current a student

EDUCATION: High School - College - Postgraduate - Other: ______

PLEASE CHECK ALL THAT APPLY
IN THE PAST 12 MONTHS - HAVE YOU HAD

GENERAL
☐ change in appetite
☐ weight loss
☐ weight gain
☐ fatigue
☐ stress

EYES
☐ loss or blurring of vision
☐ dry eyes

EARS
☐ hearing loss
☐ ringing in the ears
☐ sensation of spinning or balance difficulty

NOSE
☐ nose bleeds
☐ nasal congestion
☐ postnasal drip
☐ sinus infection, pressure, or pain

THROAT
☐ sore or infected throat
☐ trouble swallowing
☐ change in voice or speech

CARDIO
☐ chest pain or pressure
☐ palpitations
☐ swelling in legs and feet
☐ fainting

PULM
☐ cough
☐ shortness of breath
☐ wheezing
☐ painful or uncomfortable breathing

GI
☐ heartburn
☐ nausea
☐ vomiting
☐ stomach pain

GU
☐ frequent urination
☐ urgent urination
☐ bedwetting
☐ sexual dysfunction

HEME
☐ blood loss
☐ anemia or low blood counts

ENDO
☐ heat intolerance
☐ cold intolerance
☐ swelling at the base of neck
☐ increased thirst

DERM
☐ rash
☐ dry or itchy skin
☐ hives or whelps

ORTHO
☐ neckpain
☐ back pain
☐ joint pain

NEURO
☐ heachache
☐ trouble walking
☐ muscle weakness
☐ tremor
☐ loss of sensation or feeling

PSYCH
☐ depression
☐ anxiety
☐ panic attack
☐ hallucinations
☐ mania