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: (          ) ______ - ____________

Form SC-20 - page 2 of 7 (Rev. 8/21)
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   2 = moderate chance of dozing
1 = slight 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:

<table>
<thead>
<tr>
<th>Pharmacy:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME of Medication</th>
<th>DOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

________________________
________________________
________________________

Form SC-20 - page 5 of 7 (Rev. 8/21)
### Past Surgical History
- Weight loss surgery
- Tonsillectomy
- Sinus surgery
- Septoplasty

### Additional Surgeries
- 
- 
- 
- 

### Family History

<table>
<thead>
<tr>
<th>Members</th>
<th>Living or Deceased</th>
<th>Sleep Apnea</th>
<th>Insomnia</th>
<th>Restless Legs</th>
<th>Narcolepsy</th>
<th>Sleep Walking</th>
<th>High Blood Pressure</th>
<th>Stroke</th>
<th>Heart Disease</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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  
  - Yes  
  - No  
  - 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
☐ neck pain
☐ back pain
☐ joint pain

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

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