





**DO YOU HAVE ANY OF THE FOLLOWING:**

PLEASE CIRCLE ALL THAT APPLY

- |                  |            |                     |                |
|------------------|------------|---------------------|----------------|
| DRY MOUTH        | SWEATING   | NEED TO URINATE     | PANIC ATTACKS  |
| NASAL CONGESTION | NIGHTMARES | CHOKING AND GASPING | COUGHING       |
| HEADACHE         | CHEST PAIN | UNREFRESHED SLEEP   | TEETH GRINDING |
| HEARTBURN        | REFLUX     | BODY ACHES          | LEG DISCOMFORT |

DO YOU HAVE ANY TAPE OR LATEX ALLERGIES? YES NO

DO ANY OF YOUR FAMILY MEMBERS HAVE A SLEEP DISORDER? YES NO

**MEDICAL HISTORY**

PLEASE CIRCLE ALL THAT APPLY

- |        |              |                     |             |
|--------|--------------|---------------------|-------------|
| CHF    | DEPRESSION   | THYROID DISORDER    | HEAD INJURY |
| STROKE | DIABETES     | SINUS PROBLEMS      | ALLERGIES   |
| COPD   | HEART ATTACK | HIGH BLOOD PRESSURE | ASTHMA      |

PLEASE LIST ANY OTHER SIGNIFICANT MEDICAL HISTORY OF SURGERIES:

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**SLEEP AND WAKING**

1. DO YOU SNORE WHEN YOU SLEEP? YES NO
2. HAVE YOU EVER BEEN TOLD YOU STOP BREATHING AT NIGHT? YES NO
3. ARE YOU RESTLESS WHEN YOU SLEEP? YES NO
4. HAVE YOU BEEN TOLD THAT YOU WALK OR TALK IN YOUR SLEEP? YES NO
5. DO YOU ACT OUT YOUR DREAMS? YES NO

**FALLING ASLEEP**

1. ARE YOU UNABLE TO FALL ASLEEP IN 15 MINUTES OR LESS? YES NO
2. DO YOU AWAKEN OFTEN WHILE TRYING TO FALL ASLEEP? YES NO
3. DO YOU HAVE THOUGHTS RACING THROUGH YOUR MIND WHILE TRYING TO FALL ASLEEP? YES NO
4. DO YOU WATCH A CLOCK OR TV WHILE TRYING TO FALL SLEEP? YES NO