BAHAMAS NEUROLOGICAL CENTER, INC.
At The Parthenon, West Street
P.O. Box CR-54258 Nassau, Bahamas
Phone (242) 322-8763 • Fax (242) 322-8764

Sleep Study Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last. First, M.I.):*____ ☐M ☐F **DOB**: _____________________
Marital Status: ☐Single ☐Partnered ☐Separated ☐Divorced ☐Widowed
Home phone: __________________________________ Work phone: ________________________________
Address: ____________________________________
____
____

Employer: ____
Address: ____________________________________
____
____

Referral Source: ☐Physician ☐Newspaper Ad ☐Friend ☐Other *(Please specify)*: ____________________
Referring Physician: ________________________________ Phone: _______________________________
Regular Physician: ________________________________ Phone: _______________________________

Insurance Company: ____
Address: ____ Phone: ________________________________
Group #: ____ Policy #:_______________________________

Family Health History

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children ☐M ☐F		
Mother			☐M ☐F		
Sibling ☐M ☐F			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			☐M ☐F		
Grandmother *Paternal*			Grandmother *Maternal*		
Grandfather *Paternal*			Grandfather *Maternal*		

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Personal Health History

Childhood illness: ____

Height: ___________ Occupation: _____________

Weight: ___________ Years at Job: ____________

Neck Size: _________ ☐Shift Worker: ___________

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Health Habits and Personal Safety

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise

☐Sedentary (No exercise)

☐Mild exercises (i.e., climb stairs, walk 3 blocks, golf)

☐Occasional vigorous exercise (i.e., work/recreation, less than 4x/week for 30 min.)

☐Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)

Diet

Are you dieting? ☐Yes ☐No

If yes, are you on a physician prescribed medical diet? ☐Yes ☐No

Number of meals you eat in an average day? _____

Rate salt intake ☐High ☐Med ☐Low

Rate fat intake ☐High ☐Med ☐Low

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Caffeine

☐None ☐Coffee ☐Tea ☐Cola Number of cups/cans per day? __________

Alcohol

Do you drink alcohol? ☐Yes ☐No

If yes, what kind? _________________

How many drinks per week? ____

Are you concerned about the amount of alcohol that you drink? ☐Yes ☐No

Have you considered stopping? ☐Yes ☐No

Have you ever experienced blackouts? ☐Yes ☐No

Are you prone to "binge" drinking? ☐Yes ☐No

Do you drive after drinking? ☐Yes ☐No

Tobacco

Do you use tobacco? ☐Yes ☐No

☐Cigarettes __ pks./day ☐Chew __ #/day ☐Pipe __ #/day ☐Cigars __ #/day

___ Number of years Year quit_______

Drugs

Do you currently use recreational or street drugs? ☐Yes ☐No

Narcotics (heroin, morphine, opium, etc.)? ☐Yes ☐No

Marijuana? ☐Yes ☐No

Cocaine? ☐Yes ☐No

Hallucinogens (LSD, mescaline, angel dust, etc.)? ☐Yes ☐No

Stimulants? ☐Yes ☐No

Depressants (downers)? ☐Yes ☐No

Personal Safety

Do you live alone? ☐Yes ☐No

Do you have frequent falls? ☐Yes ☐No

Do you have vision or hearing loss? ☐Yes ☐No

Do you have an Advance Directive or Living Will? ☐Yes ☐No

Would you like information on the preparation of these? ☐Yes ☐No

Physical and/or mental abuse have also become major public issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse.

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Would you like to discuss this issue with your provider? ☐Yes ☐No

Check if you have, or have had any symptoms in the following areas to a significant degree, and briefly explain:

☐Heart Disease	☐High Blood Pressure	☐Heart Attack
☐Low Blood Pressure	☐Fainting	☐Dizziness
☐Headaches	☐Ringing of the Ears	☐Epilepsy
☐Blackouts	☐Hemophilia (bleeder)	☐Ulcers
☐Hernia	☐Prostate Trouble	☐Mental Problems
☐Back Trouble	☐Gout	☐Seizures
☐Asthma	☐Allergies	☐Bronchitis
☐Cancer	☐Kidney Trouble	☐Bladder Trouble
☐Eye Trouble	☐Hearing Trouble	☐Pneumonia
☐Meningitis	☐Heartburn	☐Impotence
☐Depression	☐Venereal Disease	☐Arthritis
☐Tuberculosis	☐Muscle Cramps	

Hospitalization Course:

____
____
____

Surgical History:

____
____
____

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Mental Health

Is stress a major problem for you?	☐Yes	☐No
Do you feel depressed?	☐Yes	☐No
Do you panic when stressed?	☐Yes	☐No
Do you have problems with eating or your appetite?	☐Yes	☐No
Do you cry frequently?	☐Yes	☐No
Have you ever attempted suicide?	☐Yes	☐No
Have you ever seriously thought about hurting yourself?	☐Yes	☐No
Do you have trouble sleeping?	☐Yes	☐No
Have you ever been to a counselor?	☐Yes	☐No

About Falling Asleep

What time do you usually try to fall asleep? ____________

Does this vary?____________

How long does it usually take to fall asleep? ____________

How many days each week does it take you more than 30 min. to fall asleep? _________

More than 60 minutes:____________

How often do you:

Have thoughts racing through your mind?	☐Never	☐Sometimes	☐Often
Feel sad or depressed?	☐Never	☐Sometimes	☐Often
Have anxiety?	☐Never	☐Sometimes	☐Often
Feel muscular tension?	☐Never	☐Sometimes	☐Often
Feel afraid of not being able to sleep?	☐Never	☐Sometimes	☐Often
Feel unable to move?	☐Never	☐Sometimes	☐Often
Have creeping, crawling, aching or twitching feelings in your legs?	☐Never	☐Sometimes	☐Often
Have vivid dream-like scenes even though you know you are not totally asleep?	☐Never	☐Sometimes	☐Often
Have any kind of pain or discomfort?	☐Never	☐Sometimes	☐Often
Feel afraid of the dark or anything else?	☐Never	☐Sometimes	☐Often
Suddenly become awake or alert?	☐Never	☐Sometimes	☐Often