COMPREHENSIVE
SLEEP & BREATHING

Comprehensive Sleep and Breathing, LLC
1406 McFarland Blvd, Ste C
Tuscaloosa, AL 35406
Phone: 205.343.0004

Comprehensive Sleep and Breathing - New Sleep Questionnaire

Name:	Date of birth:
Date:	

History of Present Illness

Have you been diagnosed with Sleep Apnea in the past? ☐ Yes ☐ No

Have you ever had a Sleep Study? (Date/ Physician) ☐ Yes ☐ No

Do you currently use a CPAP or BIPAP? ☐ Yes ☐ No

Snoring

Have you ever been told that you snore? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No If yes, is it ☐ Occasionally ☐ Frequently ☐ Nightly

How long have you been snoring? ☐ Months ☐ Years

How is your snoring described? ☐ Soft ☐ Medium ☐ Loud

Is your snoring worse is any of these situations: ☐ Lying on your back ☐ Drinking alcohol

Does your snoring wake up others? ☐ Yes ☐ No

Associated Symptoms

Have you ever been awakened by your own gasping/choking for air? ☐ Yes ☐ No

Have you ever been told that you stop breathing in your sleep? ☐ Yes ☐ No

Do you ever have any of the following symptoms:

Heartburn while sleeping? ☐ Yes ☐ No

Wake up to Urinate? How many times? ☐ Yes ☐ No

Dry mouth upon awakening? ☐ Yes ☐ No

Morning headache? ☐ Yes ☐ No

Recent unexplained weight gain? ☐ Yes ☐ No

Luna Sleep CENTERS, LLC

Luna Sleep Centers, LLC
521 Cahaba Park Circle Birmingham, AL 35242
Phone: 205-917-5862

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Night sweats? ☐ Yes ☐ No

Memory loss? ☐ Yes ☐ No

Decreased concentration? ☐ Yes ☐ No

Irritable in the mornings? ☐ Yes ☐ No

Sexual Dysfunction? ☐ Yes ☐ No

Have you ever experienced loss of muscle tone while you were awake, such as buckling of your knees, dropped head, or dropped jaw? ☐ Yes ☐ No

Have you ever experienced a brief loss of muscle control just after falling asleep (Sleep Paralysis)? ☐ Yes ☐ No

Have you ever experienced brief hallucinations that take place as you're falling sleep (hypnagogic hallucinations)? ☐ Yes ☐ No

Have you ever been told that you were physically acting out your dreams while sleeping? ☐ Yes ☐ No

Insomnia

Do you have a hard time falling asleep and/or staying asleep? ☐ Yes ☐ No

Is it better if you move to another place, on vacation, or on the weekends? ☐ Yes ☐ No

Do you take Over the Counter medications to help you sleep? ☐ Yes ☐ No

Do you have a clock and/or TV in your bedroom? ☐ Yes ☐ No

Around the Clock History

What time do you typically go to bed? _____

Do you work shift work? ☐ Yes ☐ No

Is your bedtime regular? ☐ Yes ☐ No

Are your Sleep times different on weekends? ☐ Yes ☐ No

What do you do before bed? ☐ Read ☐ TV ☐ Phone ☐ Computer

How long does it take for you to fall asleep? _____

How many hours of sleep do you estimate that you get each night? _____

Do you wake up throughout the night? ☐ Yes ☐ No How many times?_____

How long do you stay awake? _____

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Do you watch the clock or television when you wake up throughout the night? ☐ Yes ☐ No

What time do you wake up and get out of the bed?_____

How do you feel when you wake up? ☐ Sleepy ☐ Unrefreshed ☐ Tired ☐ Grumpy

Do you take naps during the day? ☐ Yes ☐ No how long are your naps?_____

What time of the day do you nap? _____

Are your naps refreshing? ☐ Yes ☐ No

Do you have the urge to move your legs at night? ☐ Yes ☐ No

Have you ever been diagnosed with restless leg syndrome (RLS) ☐ Yes ☐ No

Parasomnias

Have you ever experienced any of the following:

Sleep Talking? ☐ Yes ☐ No

Sleep Walking? ☐ Yes ☐ No

Teeth grinding? ☐ Yes ☐ No

Eating while sleeping? ☐ Yes ☐ No

Excessive Daytime Sleepiness

Do you feel extremely sleepy during the day? ☐ Yes ☐ No

Any safety concerns while working or driving? ☐ Yes ☐ No

Have you ever had a vehicle collision because you feel asleep while driving? ☐ Yes ☐ No

Do you use caffeine or other aids to stay awake? ☐ Yes ☐ No

Primary Care Provider _____ Pharmacy & Address_____

Drug Allergies:_____

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Please list any medications you are currently taking: ☐ No changes in last 6 months

Drug Name:	Dose:	Frequency:

Do you have any drug allergies? ☐ Yes ☐ No *if yes, then list them below*

List any medical diagnosis you have: ☐ No changes in last 6 months

List any surgeries you have had: ☐ No changes in last 6 months

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REVIEW OF SYSTEMS: Have you experienced any of the following problems in the last 30 days? **Please Check "Yes"**

GENERA/CONSTITUTIONAL	Yes	OPHTHALAMOGIC	Yes	ENT	Yes
Recent weight change	☐	Changes in vision	☐	Difficulty hearing	☐
Fever	☐	Blindness	☐	Dizziness/Vertigo	☐
Fatigue	☐	Wear Glasses/Contacts	☐	Sinus infection	☐
Appetite changes	☐	Other eye problems	☐	Sinus drainage	☐
Please list: _____		Please list: _____		Please list: _____	

ENDOCRINE	Yes	RESPIRATORY	Yes	CARDIOVASCULAR	Yes
Significant hair loss	☐	Shortness of breath	☐	Heart racing	☐
Thyroid problems	☐	Coughing up blood	☐	Chest pain	☐
Heat intolerance	☐	Wheezing	☐	Heart skipping	☐
Cold intolerance	☐	Coughing Sputum production	☐	Swelling of extremities	☐
Excessive thirst	☐			Shortness of breath lying down	☐
Please list: _____		Please list: _____		Please list: _____	

GASTROINTESTINAL	Yes	HEMATOLOGY	Yes	GENITOURINARY	Yes
Difficulty swallowing	☐	Swollen glands	☐	Blood in urine	☐
Constipation	☐	Blood transfusion	☐	Painful urination	☐
Diarrhea	☐	Prolong bleeding	☐	Overnight urination	☐
Blood in stool	☐	Easy to bruise	☐	Frequent urination	☐
Difficulty swallowing	☐				
Please list: _____		Please list: _____		Please list: _____	

MUSCULOSKELETAL	Yes	SKIN	Yes	NEUROLOGICAL	Yes
Joint pain	☐	Lumps	☐	Unusual weakness	☐
Joint swelling	☐	Itching	☐	Unusual headaches	☐
Weakness of extremities	☐	Rash	☐	Seizures	☐
Trauma to joints	☐	Changes in moles	☐	Fainting	☐

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PSYCHIATRIC		COVID/FLU VACCINES	
	Yes		Yes
Depression	☐	Flu(2022-2023)	☐
Anxiety	☐	COVID	☐
Difficulty sleeping	☐	BOOSTER	☐

Family History: (has mom, dad, siblings or children been diagnosed with any of the following) select one , if so

Heart Disease: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Cancer: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Stroke: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Hypertension: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Diabetes: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Other:(Please list) _____

Mom: ☐ Alive ☐ Deceased Age_____

If deceased, what medical complications?_____

Dad: ☐ Alive ☐ Deceased Age_____

If deceased, what medical complications?_____

Social History:

Do you smoke? ☐ Yes ☐ No If so, how many years? _____

Do you drink alcohol? ☐ Yes ☐ No How many per week? _____

Do you use recreational drugs? ☐ Yes ☐ No What kind? ☐ Tea ☐ Coffee ☐ Soda

Do you drink caffeine? ☐ Yes ☐ No How many per day?_____

Do you have any pets? ☐ Yes ☐ No

Have you traveled outside of the country in the last 5 years? ☐ Yes ☐ No

Yes, where? _____