PATIENT QUESTIONNAIRE

Date: _____

Patient Name: _____ Sex: _____ DOB: _____ Age: _____

Referring Physician: _____ Family Physician: _____

Reason for evaluation: _____

Please describe your main sleep problem(s): _____

_____

How long have you had the sleep problem(s): _____

SLEEP PATTERN:

I usually go to bed around _____ o'clock .
It usually takes _____ minutes for me to fall asleep.
Once I fall asleep, I wake up _____times at night.
When I wake up it is to (check all that apply):

- ❒ to urinate (_____ times at night)
- ❒ due to hot flash
- ❒ Other_____

When I try to fall asleep, I have racing thoughts through my mind YES / NO
When I try to fall asleep, I have an irresistible urge to move my arms and/or legs to be comfortable YES/ NO

SLEEP BREATHING:

I have been told that I stop breathing while asleep YES / NO
I wake at night choking or gasping for air YES / NO
I have been told that I snore YES / NO
I have been awakened by my own snoring YES / NO

WAKE PATTERN:

I wake up around _____ AM / PM
I usually feel refreshed what I wake up. YES / NO
I often experience morning headaches when I wake up. YES / NO
I have a dry mouth when I wake up. YES / NO
I feel okay initially but need to go back to sleep after a few hours. YES / NO
I have experienced an inability to move when falling asleep or when waking up YES / NO
I have experienced dreamlike images or hallucinations or sounds when falling asleep or when waking up YES / NO
I have experienced sudden muscle weakness in response to laughter, anger, or surprises. YES / NO

DAYTIME SLEEPINESS:

I take daytime naps YES / NO

I have fallen asleep while driving YES / NO

Use the scale below and circle the appropriate number for each question. Add your total at the end.

0= no chance of dozing 1= mild chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Sitting and reading something boring	0	1	2	3
Sitting in a boring meeting or a theater	0	1	2	3
Sitting in a passenger seat in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a nice lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total score_____

HABITS:

Do you smoke? YES / NO

If Yes, how much per day? _____

Do you drink alcohol? YES / NO

If Yes, how many drinks per week? _____

Do you drink caffeinated beverages during the day? YES / NO

If Yes, how much per day? _____

Do you currently use or have used any illicit substance? YES / NO

If yes, name of the substance _____

SOCIAL HISTORY:

Marital Status: _____

I am a shift worker on rotating shifts YES / NO

PREVIOUS SLEEP EVALUATION:

I have had previous overnight sleep studies YES / NO

I have been prescribed a CPAP or bi-level machine for home use YES / NO

Please list any medication that you have taken for sleep or for to help you stay awake:

_____

Did it help? YES / NO

FAMILY HISTORY OF SLEEP DISORDERS:

Sleep Apnea Relation: _____

Restless Leg Syndrome Relation: _____

Narcolepsy Relation: _____

MEDICAL HISTORY (Your Own):

Hypertension (high blood Pressure)	YES / NO
Diabetes	YES / NO
Coronary Artery Disease	YES / NO
CHF	YES/ NO
Reflux	YES / NO
Depression	YES / NO
Stroke	YES / NO
Fibromyalgia	YES / NO
COPD	YES/ NO
Asthma	YES / NO
Seizures	YES / NO
Menopause	YES / NO
Prostate problems	YES / NO
Erectile dysfunction/impotence	YES / NO

Other past medical problems: _____

Medications: _____

_____

Surgical history: _____

Allergies: _____

REVIEW OF SYSTEMS:

General

Weight gain compared to 1 year ago _____lbs 5 years ago____lbs

Heent	
Frequent headaches in the morning	YES / NO
Difficulty of breathing through nose	YES / NO
Previous nose surgery	YES / NO
Gastrointestine	
Frequent heartburn or indigestion	YES / NO
Difficulty swallowing	YES / NO
Genitourinary	
Urinating more than 2x per night	YES / NO
Respiratory	
Cough for more than 2-4 weeks	YES / NO
Shortness of breath or wheezing	YES / NO
Cardiovascular	
Irregular or fast heartbeat	YES / NO
Swelling in feet or ankles	YES / NO
Fainting or passing out	YES / NO
Neurologic	
Sudden loss of vision, strength, inability to speak	YES / NO

Hematologic	
Unusual bruising or bleeding	YES/NO
Musculoskeletal	
Diffuse muscle pain	YES/NO
Psychiatric	
Mood irritability	YES/NO
Anxiety	YES/NO
Depression	YES/NO
Endocrine	
Night sweating	YES/NO
Vascular	
Leg cramping	YES/NO
Mobility	
Falls due to poor balance/ muscle weakness	YES/NO
Use of a cane or wheelchair	YES/NO