

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete the front and back of all forms. Thank you!**

**Primary reason for your visit to the Sleep Disorders Center:**

\_\_\_\_\_

**Who is your primary care provider?** \_\_\_\_\_

**If the primary reason for the visit is not sleep related, please skip the sleep questionnaire and proceed and complete questions starting with the Medical History section.**

### SLEEP QUESTIONNAIRE

SLEEP QUESTIONS	YES	NO
Have you had a sleep study?		
Are you using Continuous Positive Airway Pressure (CPAP)?		
Weight Now _____ Weight 1 year ago _____ Weight 5 years ago _____ Height _____		
What time do you retire to bed with lights out?		
How long does it take for you to fall sleep? _____		
Do you wake up frequently during the night? If yes, how many times a night do you wake up? _____. How long does it take you to fall back asleep? _____		
What time do you get out of bed in the morning?		
How many hours are you asleep and how many hours are you in bed? _____/_____		
Do you go to bed later, or wake up later on days off? If so please indicate the times bed/wake _____/_____		
Are there any environmental factors that disturb your sleep such as a snoring partner or other noises, temperature, or security concerns? If so, please list: _____		
Do you feel rested when you wake up?		
Do you feel tired during the morning or afternoon?		
If yes, how long has this been a problem? _____ months/ years		
Do you snore at night? If yes, is it loud? _____ How long have you been snoring? _____ months/yrs		
Do you stop breathing at night? If yes, according to whom? _____		
Have you ever awakened with a sense of suffocation, choking, or with a snort?		
Do you actually fall asleep when (please check all that apply): <input type="checkbox"/> talking to others <input type="checkbox"/> watching TV <input type="checkbox"/> reading <input type="checkbox"/> while working		
Have you ever fallen asleep while driving or experienced drowsiness while driving in the past year? // if so did it cause an accident?	//	//

Do you nap during the day? If yes, what time do you nap? _____ How long do you nap? _____		
Do you experience any of these while in bed? Please check all that apply: <input type="checkbox"/> chest pain <input type="checkbox"/> chest palpitations <input type="checkbox"/> acid reflux/heartburn <input type="checkbox"/> night sweats <input type="checkbox"/> morning headache <input type="checkbox"/> frequent urination ( ) times		
Do you have headaches? If yes, when <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> All the time How long do they last? _____ How does it affect your ability to function? _____		
Have you ever awakened in the morning and found you were unable to move (paralyzed)?		
Do you ever imagine that you see or hear people, animals, objects, or frightening events when you are drowsy or just as you are falling asleep?		
Do you experience episodes of muscle weakness in your legs, hands, or neck when you laugh, get angry, get excited, or get startled?		
Do you grind your teeth at night?		
When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feeling in your legs that can be relieved by walking or movement?		
Has anyone told you your legs jerk while you are sleeping?		
Do you have any pain that disrupts your sleep? If yes, please describe		
Do you feel depressed?		
Has your enjoyment and participation in activities diminished?		
Do you have increased irritability?		
Do you have decreased concentration?		
Do you have nightmares? If yes, what part of the night?		
Do you smoke, drink alcohol, coffee, or any other caffeinated drink with or after dinner? Circle those that apply. Indicate the time and amount		
Have you taken medication in the past year for depression, pain, or insomnia? If yes, what medication(s) _____		

## EPWORTH SLEEPINESS SCALE

*How likely are you to dose off or fall asleep in the following situations?*

ACTIVITIES	WOULD NEVER DOSE	SLIGHT CHANCE OF DOZING	MODERATE CHANCE OF DOZING	HIGH CHANCE OF DOZING	SCORE
Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting, inactive in a public place	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after a lunch without alcohol	0	1	2	3	
Sitting in a car while stopped for a few minutes in traffic	0	1	2	3	
<b>TOTAL SCORE</b>					



**IV. LIST ALL ALLERGIES (MEDICATIONS/OTHER ALLERGIES)**

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**V. IMMUNIZATIONS**

Last flu shot? \_\_\_\_\_

Pneumonia vaccine? \_\_\_\_\_ If yes, when? \_\_\_\_\_

**VI. FAMILY HISTORY**

Has any blood relative had:

MEDICAL PROBLEMS	YES	NO	RELATIONSHIP (FATHER, MOTHER, BROTHER, SISTER, CHILDREN)
Insomnia			
Snoring/Sleep Apnea			
Diabetes Mellitus			
Hypertension			
Stroke (indicate age when it first occurred)			
Heart Attack or heart disease (indicate age when it first occurred)			
Emphysema			
Asthma			
Allergies/Hay Fever			
Anemia			
Kidney Disorders			
Cancer			
Depression			
Restless Legs Syndrome			

How many children do you have? \_\_\_\_\_

Are they healthy? \_\_\_\_\_ If not healthy, why? \_\_\_\_\_

**VI. SOCIAL HISTORY**

Where were you born? \_\_\_\_\_

Where have you lived? \_\_\_\_\_

Last grade completed in school? \_\_\_\_\_

Married How long? \_\_\_\_\_  Single  Divorced  Widowed  living with partner

Do you have pets at home? \_\_\_\_\_ What kind? \_\_\_\_\_ How many? \_\_\_\_\_

What jobs have you held (now and in the past- please circle current job or indicate if retired or on disability)? \_\_\_\_\_

Have you ever served in the military?  Yes \_\_\_\_\_  No

Have you been exposed to asbestos or chemicals? \_\_\_\_\_

Do you smoke  No  Yes Packs per Day \_\_\_\_\_ For how many years? \_\_\_\_\_

If no, did you ever?  No  Yes. Packs per Day \_\_\_\_\_ total years? \_\_\_\_\_ year you quit \_\_\_\_\_

Do you use alcohol?  No  Yes How many drinks per day? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Do you use caffeine?  No  Yes Type  Coffee  Tea  Soda

How many drinks per day? \_\_\_\_\_

## VII. SYMPTOM REVIEW

What follows are a series of simple questions about your current health. Answer with an **X** in the **Yes** or **No** column.

<b>HEAD, EYES, EARS, NOSE THROAT:</b>	<b>YES</b>	<b>NO</b>
Do you wear glasses or contact lenses?		
Do you have glaucoma?		
Do you have hearing loss?		
Do you have ringing in your ears?		
Do you have sinus pain?		
Is your nose usually blocked, have a history of allergies, or nasal polyps?		
Do you have nasal congestion at night or have difficulties breathing through your nose?		
Have you injured your nose?		
Do you have nosebleeds?		
Do you wake up with a dry mouth?		
<b>NEUROLOGICAL:</b>	<b>YES</b>	<b>NO</b>
Do you have episodes of dizziness? If yes, how often?		
Have you fainted in the last 5 years?		
Have you ever had a stroke ? What side of your body was affected?		
Have you ever had a seizure?		
Do you have headaches/migraines?		
Are the headaches changing?		
<b>CARDIAC</b>	<b>YES</b>	<b>NO</b>
Do you have chest pain or heaviness of chest at rest?		
Do you have chest pain, or heaviness of chest with activity?		
If yes to either of the last two questions, have you discussed this with your primary care doctor?		
If yes, did you have a stress test or another type of test on your heart?		
Have you ever had a heart attack? If yes, what kind of treatment did you receive (for example coronary artery bypass, heart stents)?		
Do you have swelling in your legs and ankles?		
Do you have palpitations or skipped beats?		
Do you get short of breath when you are lying down flat while awake?		
Do you exercise? If yes, how often? _____ How long do you exercise? _____		
<b>PULMONARY</b>	<b>YES</b>	<b>NO</b>
Do you cough or wheeze? If yes when: <input type="checkbox"/> Night <input type="checkbox"/> Daytime		
If you have a cough, is your cough productive, any color? Any change?		
Are you short of breath walking? Flat surface and/or incline? (Circle one or both).		
Do you wheeze with exercise or cold weather?		

Do you have a history of pneumonia? If yes, when?		
<b>SLEEP</b>	<b>YES</b>	<b>NO</b>
Do you snore at night?		
Do you stop breathing at night?		
Are you tired in the morning or fall asleep during the day?		
<b>GASTROINTESTINAL</b>	<b>YES</b>	<b>NO</b>
Do you have problems with nausea, vomiting, or diarrhea?		
Do you have heartburn, regurgitation or hiatal hernia?		
Do you have a history of stomach ulcers?		
Do you have black tarry stools or red blood in your stools?		
Do you have a history of hepatitis?		
Do you have a history of gallstones?		
Do you have a history of polyps in your colon?		
<b>GENTOURINARY</b>	<b>YES</b>	<b>NO</b>
Do you have difficulty urinating?		
How many times do you urinate at night?		
Do you experience increased urinary frequency or urgency?		
Do you have a history of kidney stones?		
Is there blood in your urine?		
Do you have problems with leaking urine when you cough or have problems controlling your bladder?		
<b>SKIN</b>		
Do you have any spots on your skin that are growing or bleed easily, or have irregular borders or irregular coloring?		
If yes, have you shown this to your primary care doctor?		
<b>EXTREMITIES</b>	<b>YES</b>	<b>NO</b>
Do you have arthritis? If yes, does it interfere with walking or sleeping?		
<b>ENDOCRINE</b>	<b>YES</b>	<b>NO</b>
Do you have thyroid problems?		
Do you have Diabetes Mellitus?		
Have you had a change in libido or sexual function?		
Do you have erectile dysfunction?		
<b>Menopause?</b> If yes, please answer the next questions:		
• Do you have night sweats? If yes, how long? _____		
• How severe? _____		
• Do you need a change in bedclothes or bedding? _____		
• Have you had any changes in your sleep pattern? _____		
• Have you had changes in the number of hours that you sleep?		