PHYSICIANS' CLINIC
of Iowa, P.C.

SLEEP MEDICINE QUESTIONNAIRE

Date of first appointment _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

Main reason for your visit: _____

Describe briefly your present symptoms (quality, location, timing, other problems): _____

_____

_____

_____

Please list the names of other health care providers you have seen for this problem: _____

_____

Date symptoms began (approximate) _____ Diagnosis given? _____

SLEEP HISTORY:

☐ Yes ☐ No Feel sleepy during the day
☐ Yes ☐ No Snore
☐ Yes ☐ No Awakened by your own snoring
☐ Yes ☐ No Wake up gasping for air
☐ Yes ☐ No Stop breathing while asleep
☐ Yes ☐ No Have restless sleep
☐ Yes ☐ No Have limb jerks while asleep

☐ Yes ☐ No Walk while asleep
☐ Yes ☐ No Talk while asleep
☐ Yes ☐ No Episodes of confusion
☐ Yes ☐ No Have vivid dreams/nightmares
☐ Yes ☐ No Have heartburn or gastric reflux
☐ Yes ☐ No Have morning headaches
☐ Yes ☐ No Have nighttime wheezing
☐ Yes ☐ No Wake up with a dry mouth

☐ Yes ☐ No Have an urge to move your legs
☐ Yes ☐ No Have a crawling feeling in your legs
☐ Yes ☐ No Usually dream during naps
☐ Yes ☐ No Feel muscle weakness with emotion (laughter, anger, etc)
☐ Yes ☐ No See or hear things when waking or falling asleep
☐ Yes ☐ No Feel like you can't move when waking or falling asleep

Do you work? ☐ Yes ☐ No (If no, please still complete your typical bedtime and rise time, as well as how long it typically takes you to fall asleep.)

What is your typical sleep schedule on **work** days? Bedtime: _____ AM / PM Rise Time: _____ AM / PM

What is your typical sleep schedule on **non-work** days? Bedtime: _____ AM / PM Rise Time: _____ AM / PM

How long does it take you to fall asleep on **work** days? _____ On **non-work** days? _____

If you have difficulty falling asleep, do you? ☐ Watch TV ☐ Read ☐ Toss & Turn ☐ Worry

Any other activities you do while trying to fall asleep? _____

How many times do you wake up at night? _____ How long does it take you to go back to sleep? _____

Do you wake up feeling tired? ☐ Yes ☐ No Do you nap or doze off during the day? ☐ Yes ☐ No Are your naps refreshing? ☐ Yes ☐ No

EPWORTH SLEEPINESS SCALE: Please estimate your risk of falling asleep in the following situations, using the following scale:
0 = No chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater or meeting)	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
As a passenger in a car for an hour without a break	
TOTAL	

Have you had a sleeping problem diagnosed in the past? ☐ Yes ☐ No

If yes, what was the problem and what treatment was recommended? _____

Did the treatment help? ☐ Yes ☐ No Where was the diagnosis made? _____

CPAP/BIPAP HISTORY: *(if applicable)*

Which type of machine do you have? ☐ CPAP ☐ BIPAP ☐ Auto ☐ BIPAP-ASV ☐ VPAP Adapt

What is the current pressure setting? _____ Where do you get your equipment? _____

Are you using the machine every night? ☐ Yes ☐ No Do you find the machine helpful? ☐ Yes ☐ No

If not, please explain: _____

Do you have any of the following problems when using your machine?

☐ Snoring ☐ Bloating/Gas ☐ Nasal congestion ☐ Dry mouth ☐ Gasping for air ☐ Morning headaches

Other problems or complaints: _____

HEALTH HABITS

Do you use caffeine? ☐ Yes ☐ No How much? _____ Daily fruit/vegetable intake? _____

☐ Exercise regularly ☐ Exercise occasionally ☐ Exercise rarely ☐ Do not exercise Type/Frequency _____

PAST MEDICAL HISTORY: *(please state when the problem started)*

☐ Yes ☐ No Headaches _____ ☐ Yes ☐ No Atrial Fibrillation/Flutter _____ ☐ Yes ☐ No Tonsillectomy _____

☐ Yes ☐ No Seizures _____ ☐ Yes ☐ No Anxiety _____ ☐ Yes ☐ No Drug Addiction _____

☐ Yes ☐ No Back or Joint Problems _____ ☐ Yes ☐ No Depression _____ ☐ Yes ☐ No Alcohol Addiction _____

☐ Yes ☐ No Chronic Pain Syndrome _____ ☐ Yes ☐ No Nasal or Throat Surgery _____

Other significant illnesses or infections: _____

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		Family Member			Family Member
☐ Yes ☐ No	Dementia		☐ Yes ☐ No	Parkinson's Disease	
☐ Yes ☐ No	Early Cardiac Death (<65 years old)		☐ Yes ☐ No	Restless Leg Syndrome	
☐ Yes ☐ No	Insomnia		☐ Yes ☐ No	Seizures	
☐ Yes ☐ No	Narcolepsy		☐ Yes ☐ No	Sleep Walking	
☐ Yes ☐ No	Obstructive Sleep Apnea				

Other conditions: _____

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General
☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Heavy Sweating/ Night Sweats
☐ Yes ☐ No Loss of Appetite
☐ Yes ☐ No Sleep Disturbances
☐ Yes ☐ No Unexplained Weight Loss/Gain
Other: _____

Eyes
☐ Yes ☐ No Blurry Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Wear Glasses
☐ Other: _____

Ear/Nose/Throat
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Mouth Sores
☐ Yes ☐ No Nasal Congestion/ Sinus Issues
☐ Yes ☐ No Hearing Loss
☐ Other: _____

Respiratory
☐ Yes ☐ No Cough
☐ Yes ☐ No COPD
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Recurrent Respiratory Infections
☐ Yes ☐ No Shortness of Breath
☐ Other: _____

Cardiovascular
☐ Yes ☐ No Chest Pain or Discomfort
☐ Yes ☐ No Swelling Feet, Ankles, Legs
☐ Yes ☐ No Irregular Heartbeat
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Varicose Veins
☐ Other: _____

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Indigestion/Heartburn
☐ Yes ☐ No Blood in Stools
☐ Yes ☐ No Change in Bowel Habits
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Swallowing Difficulties
☐ Other: _____

Psychological
☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety
☐ Other: _____

Genitourinary
☐ Yes ☐ No Painful urination
☐ Yes ☐ No Urinary Frequency
☐ Yes ☐ No Loss of Urinary Control
☐ Yes ☐ No Enlarged Prostate
☐ Yes ☐ No Difficulty Urinating
☐ Other: _____

Skin
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Itching
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Lumps or Masses
☐ Other: _____

Musculoskeletal
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Joint Swelling
☐ Yes ☐ No Back Pain
☐ Yes ☐ No Limitation of Motion
☐ Yes ☐ No Neck Pain
☐ Yes ☐ No Pain with Walking
☐ Other: _____

Endocrine
☐ Yes ☐ No Excessive Thirst/ Fluid Intake
☐ Yes ☐ No Temperature Intolerance
☐ Yes ☐ No Feeling Tired (Fatigue)
☐ Yes ☐ No Hot Flashes
☐ Other: _____

Hematologic/Lymphatic
☐ Yes ☐ No Swollen Glands
☐ Yes ☐ No Blood Clotting Problem
☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Bleeding Tendencies
☐ Other: _____

Neurological
☐ Yes ☐ No Tremors
☐ Yes ☐ No Dizzy Spells
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Headache
☐ Yes ☐ No Unsteady Gait
☐ Yes ☐ No Feeling Weak
☐ Yes ☐ No Convulsions/Seizures
☐ Other: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____