



SLEEP MEDICINE QUESTIONNAIRE

Date of first appointment _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Birthplace _____

Gender: Male Female Handedness: Right Left Ambidextrous

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? _____

Previous treatment for this problem (include physical therapy, surgery, and medications) _____

SLEEP HISTORY: Please check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Feel sleepy during the day | <input type="checkbox"/> Walk while asleep | <input type="checkbox"/> Have an urge to move your legs |
| <input type="checkbox"/> Snore | <input type="checkbox"/> Talk while asleep | <input type="checkbox"/> Have a creepy, crawly feeling in your legs |
| <input type="checkbox"/> Awakened by your own snoring | <input type="checkbox"/> Episodes of confusion | <input type="checkbox"/> Usually dream during naps |
| <input type="checkbox"/> Wake up gasping for air | <input type="checkbox"/> Have vivid dreams/nightmares | <input type="checkbox"/> Feel muscle weakness with emotion (laughter, anger, etc) |
| <input type="checkbox"/> Stop breathing while asleep | <input type="checkbox"/> Have heartburn or gastric reflux | <input type="checkbox"/> See or hear things when waking or falling asleep |
| <input type="checkbox"/> Have restless sleep | <input type="checkbox"/> Have morning headaches | <input type="checkbox"/> Feel like you can't move when waking or falling asleep |
| <input type="checkbox"/> Have limb jerks while asleep | <input type="checkbox"/> Have nighttime wheezing | <input type="checkbox"/> Wake up with a dry mouth |

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 most nights and get back to sleep? _____

How long does it take you to go back to sleep? _____

Do you nap 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: _____

PAST MEDICAL HISTORY: (please check all that apply and state when the problem started)

Headaches _____ Atrial Fibrillation/Flutter _____ Nasal or Throat Surgery _____

Seizures _____ Anxiety _____ Tonsillectomy _____

Back or Joint Problems _____ Depression _____

Chronic Pain Syndrome _____ Drug or Alcohol Addiction _____

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.

		<u>Family Member</u>			<u>Family Member</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Early Cardiac Death (<65 years old)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Syndrome	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Walking	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive Sleep Apnea	_____			

Other conditions: _____

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

Constitutional

- Fever
- Chills
- Recent Weight Gain
- Recent Weight Loss

Endocrine

- Excessive Thirst
- Heat Intolerance
- Cold Intolerance

Skin

- Skin Rash
- Skin Lump

Eyes

- Blurry Vision
- Seeing Double

Ear/Nose/Throat

- Sore Throat
- Nasal Congestion

Cardiovascular

- Chest Pain or Discomfort
- Palpitations
- Leg Swelling

Respiratory

- Wheezing
- Shortness of Breath
- Frequent Cough

Hematological

- Swollen Glands in Neck
- Easy Bleeding - Recurrent

Gastrointestinal

- Abdominal Pain
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Heartburn

Musculoskeletal

- Joint Pain
- Neck Pain
- Back Pain

Psychological

- Depression
- Anxiety

Genitourinary

- Urinary Loss of Control
- Urinary Frequency at Night
- Painful urination

Neurological

- Neurological Symptoms:

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____