PHYSICIANS' CLINIC
of Iowa, P.C.

SLEEP MEDICINE NEW PATIENT QUESTIONNAIRE

Date of first appointment _____ First Name _____ Last Name _____

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

FAMILY HISTORY:

Did anyone in your immediate family (mother, father, brother, sister) suffer from any of the following?

☐ Sleep Apnea ☐ Narcolepsy ☐ Restless Leg Syndrome ☐ Early Cardiac Death

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/hear things when waking/ falling asleep
☐ Yes ☐ No Feel like you can't move when waking/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

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

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

_____

EPWORTH SLEEPINESS SCALE: Please estimate your risk of falling asleep in the following situations, using the scale below:

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	

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing