PATIENT QUESTIONNAIRE/SLEEP APPOINTMENT

Name:_____Date:_____
(First Name) (M.I.) (Last Name)

Address:_____
(Mailing or Street Address) (City) (State) (Zip Code) (Telephone Number)

Check one: Male___ Female____ Date of Birth:___/___/___ Age: _____

Collar Size:_____ Height (inches):_____ Weight (pounds): _____

Insurance Information:_____
(Provider Name) (Insurance/Group#)

Referring Physician:_____
(Name) (Address) (Telephone #)

Other Physicians You See:_____
_____
_____

Have you had a recent weight gain? _____No _____Yes
Have you had a recent weight loss? _____No _____Yes
If yes, how much and in what length of time for any gain or loss:_____

MEDICAL HISTORY INFORMATION

Do you now have or have you ever had:

High Blood Pressure?	_____No	_____Yes	Sinus Problems?	_____No	_____Yes
Allergies?	_____No	_____Yes	Heart Problems?	_____No	_____Yes
Asthma?	_____No	_____Yes	Stroke?	_____No	_____Yes
Tonsillectomy?	_____No	_____Yes	Nasal Fracture?	_____No	_____Yes
Nasal Surgery?	_____No	_____Yes	Diabetes?	_____No	_____Yes
Arthritis?	_____No	_____Yes	Heartburn?	_____No	_____Yes

Chronic Obstructive Pulmonary Disease? _____No _____Yes
Congestive Heart Failure? _____No _____Yes
Nocturnal Esophageal Reflux? _____No _____Yes
Swelling of Hands or Feet? _____No _____Yes
Laser Surgery for Snoring? _____No _____Yes
Excessive daytime sleepiness? _____No _____Yes

Other Medical Problems: _____
_____
_____

Family History: (Allergies? Diabetes? Cancer? High Blood Pressure? Heart Problems? Tuberculosis?)
Mother: _____
Father: _____
Siblings: _____
Other: _____

Immunizations (Last Year Received):
Pneumovax: _____ Flu Shot: _____
Other (for travel, etc):____ _____ _____

Please list any prescriptions or non-prescription medications that you are currently taking and the purpose for taking each. Please include the use of oxygen and/or CPAP and any respiratory medications. (If you need more space to write in your medications, please use the back of the last page of the questionnaire):

Medication:	Dosage Times:	Reason for Medication:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Surgeries:	Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies:_____
_____
_____

List all occupations:	Years in occupation:
_____	_____
_____	_____
_____	_____

Pets at Home:_____

SLEEP HISTORY

Describe in detail what symptoms you have been experiencing that brings you to the sleep lab? _____
_____
_____
_____
_____
_____
_____

1. Normal Bedtime: Weeknights? _____ Weekends? _____
2. Normal Wake-up time: Weeknights? _____ Weekends? _____
3. When you awaken in the morning do you feel refreshed? _____Yes _____No
4. How long does it usually take you to fall asleep once the lights are turned off? _____
5. Do you awaken during the night? _____Yes _____No
6. How many times do you awaken during the night? _____
7. How long does it take for you to return to sleep upon these awakenings? _____
8. Do you take naps during the day? _____Yes _____No
   a. If yes, how often? _____ Average length: _____
   b. Do you feel refreshed upon awakening from these naps? _____Yes _____No
9. Note the positions you normally sleep in:_____Back _____Right Side _____Left Side _____Stomach
10. Are you now or have you ever been in the care of a Cardiologist? _____Yes _____ No

Please mark the appropriate space:

1.	Do you snore?	_____Yes	_____No	_____Sometimes
2.	Do you snore while lying on your back?	_____Yes	_____No	_____Sometimes
3.	Do you snore while lying on your side?	_____Yes	_____No	_____Sometimes
4.	Rate your snoring:	_____Mild	_____Moderate	_____Loud
5.	Do you hold your breath or stop breathing in your sleep?	_____Yes	_____No	_____Sometimes
6.	Do you have difficulty breathing while lying on your back?	_____Yes	_____No	_____Sometimes
7.	Do you have difficulty breathing while lying on your side?	_____Yes	_____No	_____Sometimes
8.	Do you awaken suddenly with a choking sensation or out of breath?	_____Yes	_____No	_____Sometimes
9.	Do you have gas, indigestion, or heartburn at night?	_____Yes	_____No	_____Sometimes
10.	Do you have night sweats?	_____Yes	_____No	_____Sometimes
11.	Do you awaken with headaches in the morning?	_____Yes	_____No	_____Sometimes
12.	Do you awaken with dry mouth?	_____Yes	_____No	_____Sometimes
13.	Do you have trouble breathing through your nose?	_____Yes	_____No	_____Sometimes
14.	Do you experience shortness of breath with exertion?	_____Yes	_____No	_____Sometimes
15.	Do you awaken at night to urinate?	_____Yes	_____No	_____Sometimes
16.	When you awaken from sleep, do you feel paralyzed, unable to move even though you are awake?	_____Yes	_____No	_____Sometimes
17.	When someone startles you or makes you laugh, do you get weak, fall or do your knees buckle?	_____Yes	_____No	_____Sometimes
18.	While in the process of falling asleep, do you have vivid dreams or hallucinations?	_____Yes	_____No	_____Sometimes
19.	Do you have frequent uncontrollable bouts of sleep, sleep attacks, or an irresistible urge to sleep?	_____Yes	_____No	_____Sometimes
20.	Do your legs kick or twitch frequently during the night?	_____Yes	_____No	_____Sometimes
21.	Do you have restless legs?	_____Yes	_____No	_____Sometimes
22.	Do you have problems with memory or concentration?	_____Yes	_____No	_____Sometimes
23.	Problems with impotence or lack of sexual drive?	_____Yes	_____No	_____Sometimes
24.	Are you irritable?	_____Yes	_____No	_____Sometimes
25.	Do you feel depressed?	_____Yes	_____No	_____Sometimes
26.	Do you feel anxious?	_____Yes	_____No	_____Sometimes
27.	Do you grind your teeth at night?	_____Yes	_____No	_____Sometimes
28.	Do you feel sleepy during the day?	_____Yes	_____No	_____Sometimes
29.	Do you feel fatigued during the day?	_____Yes	_____No	_____Sometimes
30.	Do you have to fight sleep while driving?	_____Yes	_____No	_____Sometimes
31.	Have you ever had a car wreck caused by sleepiness?	_____Yes	_____No	_____Sometimes
32.	At night, does your sleep disturb your bed partner's sleep?	_____Yes	_____No	_____Sometimes
33.	Do you feel rested after a typical night's sleep?	_____Yes	_____No	_____Sometimes

34. Do you currently take a non-prescription drug from the pharmacy in order to help you sleep? _____Yes _____No _____Sometimes
35. Do you currently take a non-prescription drug to stop from being so sleepy and fatigued in the daytime? _____Yes _____No _____Sometimes
36. Do you take a prescription drug to help you sleep? _____Yes _____No _____Sometimes
37. At night, does your heart pound or beat rapidly? _____Yes _____No _____Sometimes
38. Do you have trouble doing your job because of sleepiness or fatigue? _____Yes _____No _____Sometimes
39. Have you been able to sleep for several days at a time? _____Yes _____No _____Sometimes
40. Do you walk in your sleep? _____Yes _____No _____Sometimes
41. Do you often have a night full of intense dreams? _____Yes _____No _____Sometimes
42. Do you have vivid dreams during daytime naps? _____Yes _____No _____Sometimes

Please rate the chance of you dozing in the following situations:

0=would *never* doze
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 (e.g. theater or meeting):	_____
As a passenger in a car for an hour without a break:	_____
Lying down to rest in the afternoon when circumstances permit:	_____
Sitting and talking to someone:	_____
Sitting quietly after lunch without alcohol:	_____
In a car, while stopped for a few minutes in traffic:	_____
Add the numbers for a total:	TOTAL: _____

SLEEP ENVIRONMENT

1. Do you sleep in a waterbed? _____Yes _____No
2. Do you read in bed? _____Yes _____No
3. Do you watch TV in bed? _____Yes _____No
4. Do you share the bed with anyone? _____Yes _____No
5. Does your bed partner have a sleep disorder? _____Yes _____No
6. Do you have pets in the bedroom? _____Yes _____No
7. What is the temperature in your bedroom? _____

SOCIAL HISTORY

Marital Status: _____Single _____Married _____Divorced _____Separated _____Widowed
What is your present occupation? _____
What are your work hours? _____

Have you ever smoked? _____Yes _____No
If yes, for how many years? _____
Average number of packs per day: _____
Have you quit smoking? _____Yes _____No
How long ago? _____
Do you drink caffeinated beverages? _____Yes _____No
If yes, how many per day? _____
If yes, how many 2 hours prior to bedtime? _____
Do you drink alcoholic beverages? _____Yes _____No
If yes, how many per day? _____
If yes, how many 2 hours prior to bedtime? _____
Do you get regular exercise? _____Yes _____No
If yes, how often? _____
Do you have any unusual eating habits? _____Yes _____No
If yes, explain: _____
Do you have a Substance Abuse Problem? _____Yes _____No
If yes, for how many years? _____
If you have quit, when did you quit? _____

Is there any additional information that you believe is important for your physician to know about your past medical or sleep history? If so, please explain/describe:_____
_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to prepare for your first appointment.

REVIEW OF SYSTEMS (Since the Last Visit or in the Last Year Have You Had the Following?:

Weight loss (unintentional)	_____Yes	_____No	Bad indigestion	_____Yes	_____No
Change in appetite	_____Yes	_____No	Burning with urination	_____Yes	_____No
Recent fever/chills	_____Yes	_____No	Blood in urine	_____Yes	_____No
Night Sweats	_____Yes	_____No	Blood in stools or Black Stools	_____Yes	_____No
Severe Fatigue	_____Yes	_____No	Change in bowel movements (color amount, consistency)	_____Yes	_____No
Chest pain/tightness	_____Yes	_____No	History of prostate problems	_____Yes	_____No
Extreme discouragement/depression	_____Yes	_____No	Difficulty passing urine	_____Yes	_____No
Palpitations (pounding heartbeat)	_____Yes	_____No	Visual changes	_____Yes	_____No
Shortness of breath	_____Yes	_____No	Problems with walking	_____Yes	_____No
Passing out/fainting spells	_____Yes	_____No	Frequent falls	_____Yes	_____No
History of yellow jaundice or hepatitis	_____Yes	_____No	Bad dizzy spells	_____Yes	_____No
High Cholesterol	_____Yes	_____No	Unusual skin lesions	_____Yes	_____No
Transient blindness, numbness/tingling of face or extremities	_____Yes	_____No	Chronic cough	_____Yes	_____No
Wheezing	_____Yes	_____No	Joint problems	_____Yes	_____No
Abdominal pain	_____Yes	_____No	Sleep problems	_____Yes	_____No
Coughed up blood	_____Yes	_____No	Swallowing Problems	_____Yes	_____No
Nausea/vomiting	_____Yes	_____No	New onset headaches or unusual types of headaches	_____Yes	_____No

PREFERRED PHARMACY _____