NEW PATIENT QUESTIONNAIRE - SLEEP LAB

Date: ____________________

Name: ____
(first) (middle) (last)

Address: ____
(street) (city) (state) (zip)

Date of Birth: ____________________ Age: ________

Home Phone: ____________________ Work Phone: ____________________

Height: ____________ Weight: ____________ Neck size: ____________

Marital Status: ____________ Spouse's name: ____________________

Your Education: ____________________ Your Occupation: ____________________

Place of Employment: ____

In case of an Emergency contact: ____
(name) (phone) *(relationship)*

Referring Physician: ____________________ Phone: ____________

Physician's Address: ____

How did you hear about our sleep center?

- ☐ Physician
- ☐ Magazine journal
- ☐ Sleep society
- ☐ Relative
- ☐ Television
- ☐ Other: ____________________
- ☐ Friend
- ☐ Radio
- ☐ Newspaper
- ☐ Seminar

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE.

1. How many nights a week do you have a sleeping problem?
   ☐ one ☐ two ☐ three ☐ four ☐ five ☐ six ☐ seven

2. How long have you had a sleeping problem?
   ☐ weeks ☐ months ☐ years

3. Please estimate the severity of your problem(s).
   ☐ mildly severe ☐ moderately severe ☐ very severe ☐ extremely severe ☐ totally severe

4. How do you describe your sleep problem? Check all that apply to you.
   ☐ Difficulty falling asleep. ☐ Wake up during the night.
   ☐ Wake up early in the morning ☐ Difficulty awakening.

5. Have you ever consulted with any of the following to help you with a sleep problem?
   ☐ Family Physician ☐ Neurologist
   ☐ Internist ☐ Cardiologist
   ☐ Obstetrician ☐ Psychiatrist
   ☐ Chiropractor ☐ Clinical psychologist
   ☐ Osteopathic Physician ☐ Nutritionist
   ☐ Counselor ☐ Nurse
   ☐ Social Worker ☐ Other Physician
   ☐ Clergyman ☐ Other

6. Describe your main problem(s), in your own words, including when and how it (they) began.

7. What *treatment* have you received for your sleep problem?

8. What is your personal interpretation as to why you have your particular sleep/wake problem?

9. Do any other members of your family have a sleep problem? Please explain.

10. On average, how long do you sleep at night?

11. What time do you usually go to bed on weekdays?

12. What time do you usually go to bed on weekends?

13. What time do you usually get up on weekdays?

14. What time do you usually get up on weekends?

15. How long does it take you to fall asleep?

16. How many times do you typically wake up at night?

17. If you wake up, *on average*, how long do you stay awake?

18. What do you usually do when you awaken during the night?

19. When do you usually awaken during the night?

20. How do you feel after an average nights sleep?

21. Is the bedroom quiet and dark? ☐ Yes ☐ No

22. Do you sleep with someone else in your bed? ☐ Yes ☐ No

23. Do you usually sleep with someone else in your room? ☐ Yes ☐ No

24. Do you provide assistance to someone during the night? ☐ Yes ☐ No

25. Do you sleep with pets? ☐ Yes ☐ No

26. Is your sleep often disturbed by heat or cold? ☐ Yes ☐ No

27. Is your sleep often disturbed by light? ☐ Yes ☐ No

28. Is your sleep often disturbed by your bed partner? ☐ Yes ☐ No

29. Is your sleep often disturbed when you are not in your usual bed? ☐ Yes ☐ No

30. Is your sleep often disturbed by noise? ☐ Yes ☐ No

31. Do you have a lighted clock dial in the bedroom? ☐ Yes ☐ No

32. Do you worry excessively while in bed? ☐ Yes ☐ No

33. Do you sleep better away from home than at home? ☐ Yes ☐ No

34. Do you usually drink coffee or tea within two hours of your bedtime? ☐ Yes ☐ No

35. Do you do physical exercise before bedtime? ☐ Yes ☐ No

36. Do you read before falling asleep? ☐ Yes ☐ No

37. Do you watch TV in bed before falling asleep? ☐ Yes ☐ No

38. Do you routinely nap in the daytime or evening during the week? ☐ Yes ☐ No

39. Do you routinely nap in the daytime or evening on weekends? ☐ Yes ☐ No

40. Do you feel refreshed after a short nap (10 - 15 minutes)? ☐ Yes ☐ No

41. Have you felt depressed? ☐ Yes ☐ No

42. Have you experienced a personality change? ☐ Yes ☐ No

43. Have you ever seen a psychiatrist or other type of counselor? ☐ Yes ☐ No

44. Is your present social life satisfactory? ☐ Yes ☐ No

45. Does your sleep problem require you to cut back on social activity? ☐ Yes ☐ No

46. Can you think of a stressful event which occurred near the time your sleep problem began? ☐ Yes ☐ No

47. Do you work variable or rotating shifts? ☐ Yes ☐ No

48. Is your present work situation satisfactory? ☐ Yes ☐ No

49. Do you sleep better in your easy chair than in your bed? ☐ Yes ☐ No

50. If you snore, do you snore only on your back? ☐ Yes ☐ No

51. Have you stopped driving because of your sleep problem? ☐ Yes ☐ No

52. Has your weight been stable over the past year? ☐ Yes ☐ No

53. Please check the appropriate box for the following statements.

How often do you:	Never	Rarely	Sometimes	Frequently	Constantly
Awaken from sleep short of breath?	☐	☐	☐	☐	☐
Are told that you snore loudly?	☐	☐	☐	☐	☐
Awaken at night with heart burn, belching, or cough?	☐	☐	☐	☐	☐
Wake up with a headache in the morning?	☐	☐	☐	☐	☐
Have trouble sleeping when you have a cold?	☐	☐	☐	☐	☐
Fall asleep at public gatherings (movies, concerts, etc.)?	☐	☐	☐	☐	☐
Have breathing problems at night?	☐	☐	☐	☐	☐
Sweat excessively at night?	☐	☐	☐	☐	☐
Are bothered by long periods of wakefulness during the night?	☐	☐	☐	☐	☐
Notice your heart pounding or beating irregularly at night?	☐	☐	☐	☐	☐
Feel refreshed after a short nap?	☐	☐	☐	☐	☐
Fall asleep during the day?	☐	☐	☐	☐	☐
Fall asleep involuntarily?	☐	☐	☐	☐	☐
Fall asleep while reading the newspaper?	☐	☐	☐	☐	☐
Fall asleep while driving?	☐	☐	☐	☐	☐
Are you bothered by waking up too early and not being able to get back to sleep?	☐	☐	☐	☐	☐
Fall asleep during physical effort?	☐	☐	☐	☐	☐
Fall asleep while watching television?	☐	☐	☐	☐	☐
Fall asleep when laughing or crying?	☐	☐	☐	☐	☐
Fall asleep while talking to people?	☐	☐	☐	☐	☐
Feel weak as though you might fall when you are emotional (laughing crying or angry)?	☐	☐	☐	☐	☐
Have difficulty with sexual functioning?	☐	☐	☐	☐	☐
Have trouble at school or work because of sleepiness?	☐	☐	☐	☐	☐
Fallen asleep while on the job?	☐	☐	☐	☐	☐
Feel unable to move (paralyzed) when waking or falling asleep?	☐	☐	☐	☐	☐
Feel confused when you awaken from sleep?	☐	☐	☐	☐	☐
Experience vivid dreams upon awakening or falling asleep?	☐	☐	☐	☐	☐
Dream during daytime hours?	☐	☐	☐	☐	☐
Feel afraid of going to sleep?	☐	☐	☐	☐	☐
Have nightmares?	☐	☐	☐	☐	☐
Talk during sleep?	☐	☐	☐	☐	☐
Remember your dreams?	☐	☐	☐	☐	☐
Sleep walk - now or in the past?	☐	☐	☐	☐	☐
Have thoughts racing through your mind?	☐	☐	☐	☐	☐
Feel sad and depressed?	☐	☐	☐	☐	☐
Have anxiety (worry about things)?	☐	☐	☐	☐	☐
Have muscular tension?	☐	☐	☐	☐	☐
Notice parts of your body jerk?	☐	☐	☐	☐	☐
Strike out or make violent movements during sleep?	☐	☐	☐	☐	☐
Kick during the night?	☐	☐	☐	☐	☐
Have cramping in the legs at night?	☐	☐	☐	☐	☐
Experience crawling and aching feeling in your legs?	☐	☐	☐	☐	☐
Have morning jaw pain?	☐	☐	☐	☐	☐
Grind your teeth during sleep?	☐	☐	☐	☐	☐
Are bothered by pain during the day?	☐	☐	☐	☐	☐
Wake up feeling stiff in the morning?	☐	☐	☐	☐	☐
Wake up feeling sore or achy muscles?	☐	☐	☐	☐	☐
Wake up with pain in the neck, spine, or joints?	☐	☐	☐	☐	☐

54. What is your current weight? ______________________

55. What is your heaviest weight in the past? ______________________

56. How long ago were you at your heaviest weight in the past? ______________________

57. Please list other health problems you have had and the doctor who treats you for them (for example: diabetes, heart problems, high blood pressure, etc.):

Condition:	How Long?	Doctor treating you:

58. Please list any medications you take, including vitamins, over-the-counter, or non-prescription drugs:

Name	Amount (mg)	How often?	What do you take this Medication for?

59. Please list any medications or foods you are allergic to:

Medication or Food	Reaction

60. Do you smoke? ☐ Yes ☐ No
61. If you smoke, how many cigarettes per day on average? ____________
62. Have you quit smoking? ☐ Yes ☐ No
63. If you quit smoking, how long ago did you quit? ____________
64. Have you used marijuana or other mind-altering drugs? ☐ Yes ☐ No
65. On average, how many of each of the following beverages do you drink each day?

Beverage:	How Much?
Regular Coffee	
Decaffeinated Coffee	
Tea	
Cola Drinks	
Other Soft Drinks	
Beer	
Mixed Drinks	
Wine	
Hard liquor	

66. Please describe any other information pertinent to your sleep or wakefulness not previously described:

SNORING AND SLEEP APNEA SCREENING QUESTIONNAIRE

Reason for Sleep Study: ☐ Sleepiness ☐ Snoring ☐ Disturbed Sleep

Snoring

1. How many years have you been told you snore? ______________________

2. Does your snoring disturb your bed partner: .... ☐ Yes ☐ No

   Others in the next room? .... ☐ Yes ☐ No

3. Has your snoring become progressively worse? .... ☐ Yes ☐ No

   Over what period of time? ______________________

4. Do you snore every night? .... ☐ Yes ☐ No

5. Have you been told you snore when sleeping? Circle all that apply.

   On your back On your side On your stomach In a sitting position

6. On a scale of 1 to 5 (1 is minimal and 5 very loud), how loud is your snoring? ______________

7. Which pattern of snoring best describes your snoring? ______________________

   1) snoring is present almost continuously

   2) snoring is noted only occasionally and is not continuous

   3) I snore loudly then snoring and breathing stops and then I snore loudly again

8. Have you ever awakened from sleep because of your snoring? ... ☐ Yes ☐ No

9. Does any other family member snore? .... ☐ Yes ☐ No

Excessive Daytime Sleepiness Scale

1. Do you usually feel tired during the day? ☐ Yes ☐ No

Epworth Sleepiness Scale

1. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to chose the most appropriate number for each situation:

If you are currently using CPAP/BIPAP therapy please choose the most appropriate number based on how you feel using positive pressure therapy.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

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

2. How many naps do you take per day?__________ Length__________________

   Do you feel refreshed after a nap? ☐ Yes ☐ No

3. Have you been in a car accident due to falling asleep at the wheel?

   ☐ Yes ☐ No ☐ Near Miss

4. How many traffic tickets did you get because of sleepiness? ______________

5. Please describe an incident when you fell asleep during the day when you were not expecting to fall asleep.____

Apneas and Narcolepsy

Have you ever been observed to stop breathing during sleep? ☐ Yes ☐ No

If yes, how often during a night? ______

1. Do you have sudden attacks of sleepiness? ☐ Yes ☐ No
2. Have you recently noticed increased irritability or trouble thinking? ☐ Yes ☐ No
3. Has daytime sleepiness affected your job performance or your employment? ☐ Yes ☐ No
4. Do you have cataplexy? ☐ Yes ☐ No

   (Cataplexy is a brief (seconds to minutes) episode of muscle weakness e.g. jaw drop, arm or leg weakness and/or paralysis. When the attack is over, the patient is completely normal. Laughter, anger, athletic activity excitement are the usual factors that initiate attack of cataplexy.)

5. If you have cataplexy, please describe your symptoms. ______

   ______

   ______

6. Do you have episodes of waking up with your whole body paralyzed (sleep paralysis)? ☐ Yes ☐ No
7. Do you hear or see something in the beginning or the last part of sleep that is not real? (Hallucinations) ☐ Yes ☐ No

Medical History

1. Do you have difficulty breathing through the nose? .... ☐ Yes ☐ No

   If yes, all day? ☐ Yes ☐ No, only at night

2. Have you had:

   a) Tonsillectomy and/or adenoidectomy? .... ☐ Yes ☐ No

   b) Nasal or sinus surgery? .... ☐ Yes ☐ No

   c) Vocal cord surgery (polyp, nodules, etc.)? .... ☐ Yes ☐ No

   d) Any neck operations? .... ☐ Yes ☐ No

3. Have you been treated for sleep apnea? .... ☐ Yes ☐ No

   Where: ____

   How: ☐ Tracheostomy ☐ UPPP ☐ CPAP ☐ Drugs

   Did treatment improve: ☐ Sleepiness ☐ Snoring ☐ Tiredness ☐ Quality of sleep

Restless Leg Syndrome

1. Do you have restless or uncomfortable feelings in your legs? .... ☐ Yes ☐ No
2. Are these worse at night? .... ☐ Yes ☐ No
3. Are these feelings relieved by movement, even for a short period of time? .... ☐ Yes ☐ No

REVIEW OF SYSTEMS

General

1. Have you ☐ Lost ☐ Gained weight in the past 12 months? If yes, how much? ____________
2. Have you had night sweats? .... ☐ No ☐ Yes
3. Do you sleep with pets? .... ☐ No ☐ Yes

Head, Eyes, Ears, Nose, Throat

1. Do you have headaches? .... ☐ No ☐ Yes
2. Do you have a nasal drainage? .... ☐ No ☐ Yes
3. Do you sleep with pets? .... ☐ No ☐ Yes
4. Do you have:
   - Difficulty breathing through your nose? .... ☐ No ☐ Yes
   - Sore mouth? .... ☐ No ☐ Yes
   - Sore throat? .... ☐ No ☐ Yes
   - Ear pain? .... ☐ No ☐ Yes

Cardiac

1. Do you have chest pain or pressure? .... ☐ No ☐ Yes
2. Do your feet swell? .... ☐ No ☐ Yes
3. Do you have palpitations (such as skipped heartbeats or rapid heartbeats)? .... ☐ No ☐ Yes

Lungs (Pulmonary)

1. Do you cough? .... ☐ No ☐ Yes
2. Do you wheeze? .... ☐ No ☐ Yes
3. Do you get short of breath? .... ☐ No ☐ Yes
   - At rest? .... ☐ No ☐ Yes
   - With stairs? .... ☐ No ☐ Yes
   - Carrying groceries or laundry? .... ☐ No ☐ Yes
   - With strenuous effort? .... ☐ No ☐ Yes
4. Do you raise mucous? .... ☐ No ☐ Yes

Gastrointestinal

1. Do you have an difficulty with heartburn? ☐ No ☐ Yes
2. Have you had any change in your usual bowel habits recently, such as constipation, diarrhea or changes in shape, color, etc.? ☐ No ☐ Yes
3. Do you have difficulty with regurgitation of acid back into your chest or mouth? ☐ No ☐ Yes

Genitourinary

1. Do you have any difficulty passing your urine such as burning, blood, or poor stream? ☐ No ☐ Yes
2. If male, do you have difficulty with erections? ☐ No ☐ Yes
3. If female, do you leak small amounts of urine with cough, laugh or sneeze? ☐ No ☐ Yes
4. Do you wake up to urinate? ☐ No ☐ Yes
5. Compared to the past, your interest in sex is...

   ☐ about the same ☐ a little less ☐ much less ☐ no interest at all
6. How many times during the night do you go to the bathroom to urinate?

   ☐ 0-1 ☐ 2-3 ☐ 3-4 ☐ 5 or more

Musculoskeletal

1. Do you have pain or numbness in your hands, arms, legs, feet or back?

   ☐ No ☐ Yes Where ____________________ When ____________________
2. Do you get back pain?

   ☐ No ☐ Yes Where ____________________ When ____________________
3. Do you wake up with numbness or pain in your hands or arms? ☐ No ☐ Yes

Neurological

1. Do you get dizzy? ☐ No ☐ Yes
2. Do you have problems with balance or coordination? ☐ No ☐ Yes
3. Do you have shake or tremor? ☐ No ☐ Yes
4. Do you experience sudden muscular "weak knees" when you laugh, are angry or other emotional situations?

   ☐ Never ☐ Occasionally ☐ Frequently ☐ Almost always
5. Has your vision temporarily blurred or "blacked-out" recently? ☐ No ☐ Yes
6. Are you more irritable than in the past?

   ☐ No ☐ A little more ☐ Quite a bit ☐ A lot more
7. Do you experience depression?

   ☐ No ☐ A little more ☐ Quite a bit ☐ A lot more
8. Do you experience vivid dream-like images while falling asleep or when awakening from sleep?

   ☐ Never ☐ Occasionally ☐ Frequently ☐ Almost always
9. Do you awaken from sleep or a nap with the feeling that you are unable to move or are paralyzed?

   ☐ Never ☐ Occasionally ☐ Frequently ☐ Almost always

Please list any surgeries/operations that you have had:

Type of Surgery	Date	Place	Reason for Surgery

Comments: