

## Patient Questionnaire

**Please make sure to bring this completed to your sleep study**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for sleep evaluation: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Check any of the boxes that you have experienced in the past 6 months:

<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/> Chest Discomfort
<input type="checkbox"/> Weight Gain / Loss	<input type="checkbox"/> Coughing or Wheezing	<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Passing Out	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Leg / Feet Swelling
<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Muscle Aches and Cramps	<input type="checkbox"/> Trouble Breathing
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Sinus Congestion
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nausea or Vomiting
<input type="checkbox"/> Weak muscles when telling or hearing a joke	<input type="checkbox"/> Heard or seen things that were not there (as if dreaming, but awake) when walking or falling asleep	<input type="checkbox"/> Felt as if you could not move when waking or falling asleep
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Other:	<input type="checkbox"/> None

Please list all your medications, including over-the-counter meds and herbal remedies:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies to medicine? If so, please list them: \_\_\_\_\_

Do you have a history of: (Please check all boxes that apply)

<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Seizures/Other Neurological Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Drug or Alcohol Addiction	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Anxiety

Past or Current Medical Problems: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Have you had your tonsils removed?  Yes  No If so, at what age? \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you work shift work? If so, what shifts? \_\_\_\_\_

Do you smoke?  Yes  No If so, for how many years and how much? \_\_\_\_\_

Do you drink Alcohol?  Yes  No If so, how many drinks per week? \_\_\_\_\_

Do you drink coffee, caffeinated soda, or tea?  Yes  No If so, how many cups per day? \_\_\_\_\_

Is there anyone in your family with the following conditions?

<input type="checkbox"/> Seizures	<input type="checkbox"/> Dementia	<input type="checkbox"/> Excessive Sleepiness	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> None

If you marked any of the above conditions please list relationship to effected person: \_\_\_\_\_

\_\_\_\_\_

Please mark any of the below occurrences that either you or someone else has observed of you:

<input type="checkbox"/> Snoring	<input type="checkbox"/> Acting Out Dreams	<input type="checkbox"/> Wake Up Gasping For Air
<input type="checkbox"/> Leg Jerks	<input type="checkbox"/> Nighttime Wheezing	<input type="checkbox"/> Stop Breathing While Sleeping
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Vivid Dreams/Nightmares	<input type="checkbox"/> Take Sleeping Medication
<input type="checkbox"/> Talking In Sleep	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Creeping/Crawling Feeling In Legs
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Sleep Disrupting Ideas	<input type="checkbox"/> Feel The Need To Move Your Legs
<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Awaken With Dry Mouth	<input type="checkbox"/> Pain That Interferes With Sleep

Is your Nighttime sleep refreshing?  Yes  No

Are you sleepy/fatigued during the day?  Yes  No If yes, what time of day is worse? \_\_\_\_\_

If you snore, what sleeping positions do you snore in?  Back  Side  Stomach

Does your snoring disturb others?  Yes  No

What positions do you sleep in:  Back  Side  Stomach

Mark any of the following that you do while you are in bed:

Read  Eat  Watch TV  Do work activities  Sleep with the TV on

How many times do you wake to use the restroom? \_\_\_\_\_

How long does it take you to fall back to sleep? \_\_\_\_\_ If you have difficulty falling asleep, what do you do? \_\_\_\_\_

Do you take naps?  Yes  No If yes, how long are they? \_\_\_\_\_

Do you dream during the naps?  Yes  No Are the naps refreshing?  Yes  No

Do you exercise?  Yes  No If yes, what time of day do you exercise? \_\_\_\_\_

Estimate your risk of falling asleep or dozing off in the following situations, using the following scale:

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

Sitting and reading : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Lying down to rest in the afternoon : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Watching TV : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	As a passenger in a car, for an hour, with no break : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting, inactive, in public (Theater, Meetings, Etc.) : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Sitting quietly after lunch, without Alcohol: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting and talking to someone: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	In a car, stopped in traffic, for a few minutes: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

<b>Sleep Schedule:</b>	<b>Bedtime:</b>	<b>Rise Time:</b>	<b>How long to fall asleep</b>
<b>Work Days</b>			
<b>Days Off</b>			