Sleep Clinic
Patient Information Questionnaire

Name: _____ Date: _____
Telephone Numbers: Home:( )_____ Work:( )_____Cell:( )_____
Referring Physician: _____
Primary Care Physician: _____

( )Daytime Sleepiness ( )Difficulty falling asleep ( ) Difficulty staying asleep
( )Not feeling rested in the morning ( ) Behaviors during sleep
( ) Early awakening ( )Other: _____

Please describe your sleep problem(s):

_____
_____

How long have you had a sleep problem?

_____
_____

How many nights a week do you have a sleep problem?

_____
_____

Have you had a prior sleep study? ( )No ( )Yes When? _____ Where?_____

Do you use a CPAP or BPAP? ( )No ( )Yes *If you answered yes, please bring your CPAP and mask to the clinic, and answer the following questions:*
CPAP company: _____ CPAP or BPAP level: _____
Mask: ( )Nasal ( )Full type:_____ Humidity:_____ Heated:_____
None:____
Problems with CPAP: _____
Pressure issues: Too High_____Too Low:_____ Sinus Congestion: _____
Mask fit/comfort: _____ Mask Leak:_____ If yes, where do you feel the air: _____.

Have you had surgery for sleep apnea? ( )No ( )Yes
Type: _____When:_____
Do you use oxygen during the day or night? ( )No ( )Yes
If yes, how much and when?: _____

Snoring and Breathing During Sleep Symptoms:
Do you snore? ( )No ( ) Yes
If yes, is it: ( )Mild ( )Moderate ( )Loud ( )Very Loud
How often do you snore? ( )Every night ( )Usually ( ) Sometimes
Has anyone told you that you stop breathing while asleep? ( )No ( )Yes
Do you sometimes wake up gasping for breath? ( )No ( )Yes

Daytime Sleepiness and Other Symptoms:
Do you have trouble staying awake during the day? ( )No ( )Yes
Do you have trouble at work or school because of sleepiness? ( )No ( )Yes
Do you have trouble staying awake while driving? ( )No ( )Yes
Do you ever feel weak (knee buckle) when emotional (anger, surprise, laughing)?
( )No ( )Yes If yes, how long does the episodes last? _____
Do you ever feel paralyzed (can't move) when falling asleep or waking up?
( )No ( )Yes
Do you have dreams or visions as you fall asleep or as you wake up?
( )No ( )Yes If yes, how often:_____ Describe the events:
_____
_____

How **LIKELY** are you to **DOZE OFF** or **FALL ASLEEP** in the following situations, **in contrast to feeling tired?** This refers to your **usual way of life in recent times**. Even if you have not done some these things recently, try to work out how they would have affected you. Please select one response per line.

CHANCE OF DOZING OFF:

	Never	Slight	Moderate	High
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (ex: theater or a 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				

Sleep Quality/Habits:

On average, how do you feel when you get in the morning (check all that apply to you)? ( )Rested ( )Tired ( )Sleepy ( )Groggy ( )Exhausted
What time do you usually go to bed? _____ What time do you usually get up?_____
On average, how long does it take you to fall asleep? _____
On average, how many times do you wake during the night? _____
On average, how long are you awake in the morning before you get up? _____
On average, how many hours do you actually sleep at night? _____
Do you take any kind of medications or use alcoholic beverages to help you fall asleep? ( )No ( )Yes If yes, what do you take? _____
Do you take naps? ( )No ( )Yes If yes, how long? _____
Can you see a clock face from your bed? ( )No ( )Yes
How many caffeinated beverages do you drink each day? _____
Do you sleep in on the weekends? ( )No ( )Yes
Do your bedtimes and wake times vary? ( )No ( )A little ( )A lot
Do you work evenings, nights (3 to 11 PM or 11PM to 7AM), split or rotating shifts? ( )No ( )Yes Is yes, please describe? _____
What is your usual sleeping position (check all that apply)?
( )Back ( )Side ( )Stomach

Unusual Behavior During Sleep:

Do you have any unusual behavior during sleep? ( )Yes ( )No. If you answered yes, how long? _____
Is yes, please check the type of behavior:
Sleep Walking _____ Acting out dreams _____ Talking _____
Yelling or screaming _____ violent behavior (hitting, swinging) _____
Lip smacking or unusual mouth movements _____ grinding teeth _____
Other behavior or activity: _____

Leg Symptoms:

Do you ever feel like you just have to move your legs? ( )Yes ( )No
Do you ever have unpleasant creepy/crawly feelings in your legs? ( )Yes ( )No
Do these creepy/crawly feelings in your legs and the feeling like you have to move your legs ever occur together, that is , at the same time? ( )Yes ( )No
If yes: How often does this situation occur: _____
Do these feelings occur mainly when you are resting? ( )Yes ( )No
Do these feelings improve with movement: ( )Yes ( )No
Are these feelings worse in the evening than in the morning:
( )Yes ( )No

Past Medical History: (Put an X if you have or have had these problems)

Hypertension (High Blood Pressure): _____
Chronic bronchitlis/emphysema: _____
Diabetes: _____

Depression: _____
Stroke: _____
Pacemaker: _____
High Cholesterol: _____
Hepatitis: _____
Angina/Heart Attack: _____
Cancer: _____
Type: _____

GYN: Women
Last menstrual period: _____ Pregnancies: _____
Deliveries: _____

Other medical problems:
_____
_____

List allergies to medications: _____
List medications you are currently taking, including non-prescription drugs:

Drug	Dosage	Times per day	Reason

List all surgeries that you have had and approximate dates if possible:

1: _____ 7:_____
2: _____ 8:_____
3: _____9:_____
4:_____10:_____
5:_____11:_____
6:_____12:_____

Family History:
List major illnesses, including sleep problems experienced by your parents and siblings:
_____
_____
_____

Social History:
Occupation: _____ Marital Status: _____
Children at home: _____
Have you ever smoked? ( ) Yes ( )No Are you currently smoking? ( )Yes ( )No
If you ever smoked, how many packs per day? _____ How many years have you smoked? _____ If you quit, how many years ago did you quit? _____
Do you drink alcohol? ( )Yes ( )No How much? _____

Review of Systems: (please check all that apply to you)

	Yes	No
Constitutional:		
Weight loss		
Weight gain		
Fevers		
Night sweats		
Allergic/Immunization: (date given)		
Pneumonia Vaccination:_____		
Influenza Vaccination: _____		
Eyes:		
Change in vision		
Cataract Surgery		
Glaucoma		

	Yes	No
Ears/Nose/Mouth/Throat:		
Change in hearing		
Decreased hearing		
Ear infections		
Vertigo		
Nasal congestion		
Seasonal runny nose		
Nasal bleeding		
Sore in mouth		
Dentures:		
Upper: ___ Lower:___ Both:_____		
Pain in jaw joint: TMJ		
Hoarseness		
Neck masses		
Neck gland swelling		
Noisy breathing		
Cardiovascular:		
Chest pain		
Irregular/rapid pulse		
Heart murmur		
Pacemaker		
Heart failure		
Rheumatic fever		
Previous heart attack		
Let swelling		
Can't sleep flat because of breathing issues		
Respiratory:		
Chronic cough		
Shortness of breath		
Coughing up blood		
Lung collapse		
Wheezing/asthma		
Previous TB		
Positive TB Skin Test		
Gastrointestinal:		
Difficulty swallowing		
Indigestion		
Ulcers		
Heartburn		

	Yes	No
Black tarry stools		
Blood in the stool		
Constipation		
Jaundice/Hepatitis		
Genitourinary		
Burning on urination		
Blood in the urine		
Loss of bladder control		
Kidney stones		
Men:		
Enlarged Prostate		
Difficulty starting urine stream		
Women:		
Irregular periods		
Last menstrual period		
Vaginal discharge		
Hematology/Lymphatic:		
Anemia (low blood count)		
Bleeding tendency		
Swollen lymph nodes (glands)		
Endocrine:		
Thyroid disease		
Goiter (enlarged thyroid)		
Cold intolerance		
Integumentary:		
New or larger pigmented spots		
Dry skin		
Skin cancers		
Musculoskeletal:		
Painful joints		
Swollen joints		
Red joints		
Edema		
Neurological:		
Frequent headaches		
Loss of consciousness		

	Yes	Yes
Numbness and tingling		
Previous stroke		
Sudden loss of vision		
Seizures		
Weakness		
Psychiatric:		
Depression		
Bipolar disorder		
ADD/ADHD		
PTSD		
Anxiety		

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little or not interested in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping to much				
Feeling tired or having too little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way.				

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

( )Not difficult at all ( )Somewhat difficult ( )Very difficult ( )Extremely difficult

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				

week 1

week 2