

Please complete this questionnaire and return prior to your appointment if possible.

1. The reason why you are here today (**Circle**):
Excessive daytime sleepiness, fatigue, frequent awakenings at night, insomnia, observed pauses in breathing, snoring, unrefreshed sleep, update supplies
Other: _____
2. How long have you had these symptoms? _____
3. What is your usual bedtime? _____
4. How long does it take you to fall asleep? _____
5. Do you snore? Yes No
6. Has anyone ever noticed you quit breathing while you are asleep? Yes No
7. Does your spouse/partner sleep separately from you due to snoring? Yes No
8. How many times do you usually wake up at night? _____
9. Why do you wake up at night? (**Circle**):
Bathroom, choking, gasping for air, noise, pain, snoring, unknown reason
Other: _____
11. Do you toss, turn and/or twitch in your sleep? Yes No
12. Do you recall having dreams at night? Yes No
13. What time do you usually get out of bed in the morning? _____
14. Do you feel refreshed when you wake in the morning? Yes No
15. Do you have a morning headache? Yes No
- a. When does it normally resolve? _____
16. Do you feel sleepy or fatigued during the day? Yes No
17. Have you ever fallen asleep while driving? Yes No
18. Do you take naps during the day? Yes No
19. If you fall asleep during the day, do you dream? Yes No
- Have you had a sleep study before?** Yes No

Date and Location: _____

1. Have you ever been unable to move upon waking from sleep? Yes No
2. Do you talk in your sleep? Yes No
3. Do you walk in your sleep? Yes No
4. Have you ever acted out dreams in your sleep? Yes No
5. Have you ever felt weak in the knees when startled or emotional? Yes No
6. Are you bothered by creepy, crawly, restless sensations in your legs when you are still? Yes No
7. Do you have a problem with memory or concentration? Yes No

If you are a current CPAP or BiPAP user, please bring your memory card or machine with power cord. Bring your mask.

EPWORTH SLEEPINESS SCALE

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 of life 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 choose the most appropriate number for each situation:

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	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place, i.e. a theater or meeting	0 1 2 3
As a passenger in a car	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (without alcohol)	0 1 2 3
In a car as a driver, while driving, or at a stop light in traffic	0 1 2 3

If you have the following medical conditions, please circle:

Anemia, anxiety, arrhythmia, arthritis, asthma, attention deficit, claustrophobia, congestive heart failure, coronary heart disease, depression, diabetes, dysphagia, epilepsy, emphysema, fibromyalgia, gastroesophageal reflux disease, gout, hypertension, hypothyroidism, impotence, insulin resistance, mood disorder, multiple sclerosis, pacemaker, Parkinson’s disease, stroke – when_____.

Please list any other medical conditions that you are being treated for:

What is your occupation? _____

Do you or did you smoke cigarettes? []Yes []No

How much? _____ (pack per day) For how many years? _____

When did you quit? _____

Do you drink alcohol? []Yes []No

How much? _____ How often? _____

Do you drink caffeinated beverages? []Yes []No

How much? _____ How often? _____

Do you have family members with sleep disorders such as sleep apnea or snoring? []Yes []No

Mark where applicable

	Mother	Father	Sibling	Grandparent	Other
Snoring					
Sleep Apnea – Treated					
Sleep Apnea - Untreated					

Please bring a list of your current medications

Allergies to medications? []Yes []No

Please list: _____

Constitutional:

In the past 5 years, has your weight changed? Pounds gained: _____ Pounds lost: _____

Do you have problems with any of the following? Check all that apply.

Heart

- high blood pressure
- palpitations
- chest pain
- irregular heart rate/pulse
- leg or foot swelling
- have to sleep sitting up

Other: _____

Respiratory

- shortness of Breath
- wheeze
- sputum production
- chronic cough

Other: _____

Gastrointestinal

- heartburn
- difficulty Swallowing
- nausea
- vomiting
- diarrhea
- abdominal pain

Other: _____

Urinary

- incontinence
- frequency
- urgency
- impotence

Other: _____

Neurological

- headaches
- seizure
- head trauma
- disorientation
- gait or balance problems
- fainting or unconsciousness

Other: _____

Psychiatric

- Attention Deficit Hyperactivity
- anxiety
- depression
- mood disorder
- claustrophobia

Other: _____

Ears/Nose/Throat

- nasal congestion
- sinus problems
- nose bleeds
- dry mouth/throat
- hoarseness
- injury to nose
- tonsillectomy
- wisdom teeth removed

Other: _____

Endocrine

- thyroid disease
- history of goiter
- tired /sluggish
- too hot or cold
- excessive thirst
- increased appetite
- increased urination
- unexplained weakness

Other: _____

Musculoskeletal

- joint pain / stiffness
- neck pain
- back pain
- joint swelling
- muscle pain/cramping
- mobility problems

Other: _____

Allergic/Immunological

- sneezing/runny nose
- rash
- itching
- allergies to food or environment

Other: _____

Comments:

Patient signature _____