**WhidbeyHealth Sleep Care**
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# Please complete this questionnaire and return prior to your appointment if possible.

Name:_____ Date:_____

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:** _____

20. Have you ever been unable to move upon waking from sleep? [ ]Yes [ ]No
21. Do you walk in your sleep? [ ]Yes [ ]No
22. Do you talk in your sleep? [ ]Yes [ ]No
23. Have you ever acted out dreams in your sleep? [ ]Yes [ ]No
24. Have you ever felt weak in the knees when startled or emotional? [ ]Yes [ ]No
25. Are you bothered by creepy, crawly, restless sensations in your legs when you are still? [ ]Yes [ ]No
26. 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.*



Patient label

***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_____