

Sleep Clinic
Patient Questionnaire
(Page 1 of 3)
7030-001 MR 09/09

Patient Name: _____ Nickname: _____

Referring Physician: _____ Office Phone Number: (____) _____ - _____

Address: _____
Street City State Zip

What are the patient's main sleep complaints? Check and explain all that apply.

<u>Complaint</u>	<u>How often per week?</u>	<u>How long has this been a problem?</u>
<input type="checkbox"/> Feeling sleepy most of the time	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Difficulty falling asleep	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Difficulty staying asleep	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Sleep-walking	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Sleep terror	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Loud snoring	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years
<input type="checkbox"/> Other: _____	_____	_____ <input type="checkbox"/> Months <input type="checkbox"/> Years

Has the patient had any previous sleep evaluation? No Yes (see below)

Name of Hospital or Sleep Center: _____

Address: _____
Street City State Zip

Has the patient had a sleep study? No Yes, approximate date: _____

Allergies: _____ None

Immunizations Up-to-Date: Yes Unknown No, explain: _____

Current Medications (prescribed and over-the-counter)/Herbal Preparations/Dietary Supplements: None

Medical History/Review of System:

- a. Was the patient born prematurely? No Yes, how many weeks early? _____
- b. Does the patient have seasonal allergies? Not at all Rarely Only in the spring Only in the fall Continuously
- c. Does the patient have sinusitis? Not at all Rarely Occasionally Frequently Chronic
- d. Has the patient's weight changed in the last 6 months? No Yes, gained _____ pounds Yes, lost _____ pounds
- e. Has the patient had any of the following? Check all that apply.
 - Anxiety disorder Depression Persistent headaches
 - Apnea Diabetes and/or high blood sugar Gastroesophageal reflux (GERD)
 - Asthma Encephalitis Seizures (Active Controlled by medication)
 - Attention deficit disorder (ADHD) Head injury (Minor Serious) Thyroid disease
 - Bipolar disorder Heart disease Tonsil or adenoid enlargement
 - Broken nose Meningitis Other: _____
 - Chronic lung disease Persistent nasal congestion Other: _____
- f. Has the patient had his/her tonsils removed? No Yes, at what age? _____
- g. Has the patient ever had surgery? No Yes, what kind and at what age? _____
- h. Does the patient have any chronic illnesses? No Yes, describe: _____
- i. Has the patient ever had to stay in the hospital? No Yes, why? _____

**Sleep Clinic
Patient Questionnaire
(Page 2 of 3)**
7030-001 MR 09/09

Behavior

Which of the following are true about the patient? Check all that apply..

- Has trouble in school.
- Is easily distracted.
- Is easily upset or irritated.
- Is a worrier.
- Does not seem to listen when spoken to.
- Has trouble relating with children the same age.
- Has trouble making or keeping friends.
- Has trouble organizing tasks and activities.
- Seems hyperactive (“on the go” or acts as if “driven by a motor”).
- Interrupts when others are talking or intrudes on others’ activities.
- Has other behavior problems (explain): _____

Sleep-Related History

How often or how much is the patient bothered by each problem below? On a scale from 1 to 7, with 1 being never and 7 being always, check one box for each item.

The patient does the following:	<u>Never</u>	<u>Rarely</u>	<u>Seldom</u>	<u>Occasionally</u>	<u>Often</u>	<u>Very Often</u>	<u>Always</u>
a. Snores.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Stops breathing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wakes up with breakthrough choking or gasping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Has dryness of the throat on awakening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Has a headache on awakening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feels very sleepy or groggy on awakening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Awakens feeling unrested even after adequate hours of sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Is bothered by sleepiness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Feels completely paralyzed or stuck when just falling asleep or waking up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Hallucinates (sees people or hears voices or sounds that are not really in the room) when just falling asleep or waking up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Has episodes of sudden muscular weakness when laughing, angry, or in other emotional situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Has very colorful and vivid dreams.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Grinds teeth while sleeping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Experiences bed wetting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Has an irresistible urge to move legs in the evening or at night. If this is true, which of the following does the patient experience that causes the urge to move legs? <input type="checkbox"/> Aching <input type="checkbox"/> Crawling <input type="checkbox"/> Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Kicks or twitches legs during sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Has difficulty falling asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Wakes up and has trouble falling back asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Wakes up screaming.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Experiences sleep-walking.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Behaves violently in his/her dreams.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Eats in his/her dreams.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Experiences confusion in his/her dreams.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Has nightmares.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. Acts out to his/her dreams.**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z. **For the previous 7 statements (s through y), if applicable, how often does the patient remember these events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUED ON NEXT PAGE

Sleep Habits

- a. What time does the patient usually go to bed on weekdays? _____ AM PM
- b. What time does the patient usually go to bed on weekends? _____ AM PM
- c. How long does it take the patient to fall asleep after all the lights are out? _____ minutes hours
- d. What time does the patient usually get up on weekdays? _____ AM PM
- e. What time does the patient usually get up on weekends? _____ AM PM
- f. How many times in one night does the patient wake up while sleeping? _____ times
- g. Does the patient have a TV or radio in the patient's bedroom? No Yes (see below)
If yes: Is the TV or radio on while the patient is sleeping? No Yes
- h. Does the patient take naps during the day? No Yes (see below)
If yes: How many minutes does the patient nap and at what time? _____ minutes at _____ AM PM
Does the patient feel refreshed after a short (10-15 minute) nap? No Yes
- i. Does the patient fall asleep more easily in some place other than his/her own bed? No Yes (see below)
If yes: Where? _____

Eating/Drinking Habits

- a. Does the patient drink coffee? No Yes (see below)
If yes: How many cups per day? _____ cups What time is the last drink before going to bed? _____ AM PM
- b. Does the patient drink tea? No Yes (see below)
If yes: How many cups per day? _____ cups What time is the last drink before going to bed? _____ AM PM
- c. Does the patient drink cola or other caffeinated soda? No Yes (see below)
If yes: How many cups per day? _____ cans What time is the last drink before going to bed? _____ AM PM
- d. Does the patient eat chocolate? No Yes (see below)
If yes: How many bars per day? _____ bars How many days per week? _____ days

Family History

Have the patient's *blood* relatives (parents, grandparents, aunts, uncles, brothers, sisters), living or deceased, had a sleep disorder?
Check all that apply.

- No Obstructive sleep apnea Narcolepsy Restless leg syndrome (RLS) Periodic Limb Movement (PLM)
- Other (describe): _____

Signature of Person Completing This Form

Printed Name of Person Completing This Form

Relationship to Patient

_____/_____/_____
Date

STAFF USE ONLY: All Other Systems Negative

Reviewed By: _____ Signature _____ Title _____ Date _____/_____/_____ hours _____ Time