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New Sleep Patient Questionnaire

Name_____
Age _____
Date _____

General Medical History

1. Please list any ***surgeries*** you have had and their approximate dates:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Please list any ***allergies*** to medications:

_____	_____
_____	_____
_____	_____

3. List any prescribed ***medications***:

Medication	***Dose***	***Frequency***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. List any ***over the counter*** or ***alternative medications*** you frequently use:

_____ _____
_____ _____
_____ _____

5. List any major ***medical illnesses*** you have had (e.g. heart or lung problems, ulcers, acid reflux, strokes, high blood pressure, diabetes, congestive heart failure, cancer, thyroid, depression, anxiety, heart rhythm problems, anemia, asthma, emphysema, COPD, sleep apnea):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History

List any ***medical problems*** or ***cause of death*** of your immediate family (blood relatives):

Relative	*Medical Problems*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

1. What is your present **occupation** _____
2. What **other occupations** have you had _____
   _____
3. Yes No Have you had any risk factors for **AIDS/HIV** (blood transfusions, IV drugs, sex with someone with AIDS, hemophilia, homosexual
4. Yes No Do you or have you used illicit street **drugs?** If yes, what type: _____
   _____
5. **Marital status** Single Married Divorced Widowed
6. Yes No Any **children** if yes, how many _____
7. Yes No Recent **travel** outside of the Midwest over the past year? If yes, where:_____
   _____
8. Yes No Exposure to **Tuberculosis?** If yes, to whom _____
9. Yes No Have you had PPD or **Tuberculosis** skin test? Result_____
10. Yes No Have you *ever* **smoked?** Cigar Cigarettes Pipe Chewing Tobacco
    How many packs per day *at the most* _____
    How many years *at the most* _____
    When did you quit _____
11. Yes No Have you been exposed to significant **second hand smoke**
    By whom _____
12. Yes No Have you had significant exposure to **birds**, chickens, or bird droppings

13. Yes No Have you had significant **occupational exposure** to dust, fumes, chemicals, asbestos, silica, radon, radiation? _____
14. What type of **pets** do you have _____
15. How many **caffeinated beverages** do you drink in a day _____
16. How much **alcohol** do you consume (beer, wine, liquor) _____
17. Yes No Have you ever been an **alcoholic** in the past?

Review of Systems

Have you recently had any of the following? Circle Yes or No. If unsure, leave blank.

Cardiopulmonary

Yes No Severe shortness of breath
Yes No Chest pain if yes, please describe _____
Yes No Cough if yes, please describe_____
Yes No Phlegm/Sputum if yes, what color is it _____
Yes No Blood in sputum
Yes No Swelling of ankles
Yes No Palpitations (funny heart beats)
Yes No Trouble breathing when lying flat in bed: if yes, how many pillows do you use _____

General

Yes No Tire easily/severe fatigue
Yes No Recent weight change if yes, How much_____
Yes No Night Sweats
Yes No Persistent Fevers
Yes No Chills

Skin

Yes No Itch
Yes No Rash if yes, What part of the body _____
Yes No Change in hair, nails, or color if yes, Explain _____

Head/Eyes/Ears/Nose/Throat

Yes No Trouble with vision
Yes No Eye pain/swelling/redness
Yes No Wear glasses/corrective lenses
Yes No Loss of smell
Yes No Nasal obstruction
Yes No Nosebleeds
Yes No Sinus problems
Yes No Post nasal drip
Yes No Sore throat
Yes No Hoarseness
Yes No Sore tongue or gums

Genitourinary

Yes No Increase in frequency of urination
Yes No Frequent night time urination How many times per night _____
Yes No Pain or burning on urination
Yes No Blood in urine

Digestive System

Yes	No	Change in appetite	if yes, Explain _____
Yes	No	Difficulty swallowing	if yes, Solids or liquids or both? _____
Yes	No	Heartburn	
Yes	No	Indigestion	
Yes	No	Feeling of acid in the throat	
Yes	No	Nausea	
Yes	No	Vomiting	
Yes	No	Vomiting blood or dark coffee grounds	
Yes	No	Rectal bleeding	
Yes	No	Black, tarry stools	
Yes	No	Yellow Jaundice	
Yes	No	Diarrhea	
Yes	No	Severe constipation	

Hematology

Yes	No	Swollen glands	if yes, What part of the body _____
Yes	No	Anemia	
Yes	No	Easy bruising	

Allergy/Immunology

Yes	No	Environmental allergies	if yes, To what? _____
Yes	No	Allergy shots	
Yes	No	Seen an allergist	if yes, Who? _____
Yes	No	"Flu shot" this year	
Yes	No	"Pneumonia shot" in past	

Endocrinology

Yes	No	Thyroid problems
Yes	No	Adrenal problems
Yes	No	Excess thirst
Yes	No	Excess hunger
Yes	No	Excess sensitivity to cold
Yes	No	Excess sensitivity to heat

Nervous System

Yes	No	Severe or New Headaches	
Yes	No	Dizziness	
Yes	No	Fainting	
Yes	No	Convulsions/seizures/fits	
Yes	No	Sleeplessness	
Yes	No	Depression	
Yes	No	Anxiety	
Yes	No	Memory loss	
Yes	No	Poor coordination	
Yes	No	Weakness	if yes, What part of the body _____
Yes	No	Paralysis	if yes, What part of the body _____

Date Reviewed & Discussed with Patient _____

Physician Signature_____

THE EPWORTH SLEEPINESS SCALE

NAME:_____
DATE:_____

How likely are you to doze off, or fall asleep in the following situations,
(not feelings of tiredness). This refers to your usual way of life in recent times.
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

Sitting and reading_____ _____

Watching TV _____ _____

Sitting, inactive in a public place (movies) _____

As a passenger in a car for an hour without
a break_____ _____

Lying down in the afternoon_____ _____

Sitting and talking to someone_____ _____

Sitting quietly after lunch (no alcohol)____ _____

In a car, while stopped for a few minutes _____

TOTAL SCORE _____

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Sleep Questionnaire

Name _____

Date _____

What is your **major complaint** about your sleep?_____

_____

How long have you had this problem? _____

1. What time do you **go to bed**? Weekdays_____ Weekends_____
2. How many minutes does it take to **fall asleep** on average? _____
3. Do you **snore**? Yes No
4. Do you **sleep alone** due to the loudness of your snoring? Yes No
5. Do you **snort or gasp** for air while asleep? Yes No
6. Do you or someone else notice that you **stop breathing** at night? Yes No
7. Do you have **restless sleep** or thrash at night? Yes No
8. How many times do you **awaken** after you fall asleep in general? _____
9. How many times do you **urinate** at night? _____
10. What time do you **start the day**? Weekdays_____ Weekends_____
11. How many **hours of sleep** do you get? Weekdays_____ Weekends _____
12. Do you feel **refreshed** when you wake up? Yes No
13. Do you have **headaches** when you wake up? Yes No
14. Do you have **dry or sore throat** when you wake up? Yes No
15. Are you **excessively sleepy** during the day? Yes No
16. Does your sleepiness affect your **ability to do your job**? Yes No
17. Do you feel sleepy at the **wheel of a car**? Yes No
18. Have you fallen asleep at the wheel of a **car**? Yes No
19. Do you take **naps**? Yes No

    Are your naps refreshing Yes No
20. Have you had **hallucinations** associated with your sleep? Yes No
21. Have you had any **drop attacks** or sudden weakness? Yes No
22. Have you felt **paralyzed** coming out of sleep? Yes No
23. Do you have trouble with **memory or concentration**? Yes No
24. Do you have persistent problems with **insomnia**? Yes No
25. Do you have **night sweats**? Yes No
26. Have you noticed **swelling** of your legs? Yes No
27. Have you **gained weight** recently? Yes No

    How much? _____ Over what time period? _____
28. Are you currently **depressed**? Yes No
29. Do you have **restless legs**? Yes No
30. What have you tried to improve your sleep? _____

_____