



PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

City/State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Date of Birth: _____ Age: _____ Marital Status: _____

Height: _____ Weight: _____ Gender: M F

Occupation: _____ Employer: _____

Family Physician (full name please): _____

Referring Physician (full name please): _____

1. Briefly describe your sleep problem: _____

2. Have you now or ever in the past experienced any health problems in the following areas?
If so, please indicate dates, types of problem and treatment, if any.

Lungs/Breathing Y N _____

Heart/Circulation Y N _____

Blood Pressure Y N _____

Weight Gain Y N _____

Diabetes/Thyroid Y N _____

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Stomach/Digestion Y N _____
Kidneys/Bowels Y N _____
Eyes/Ears/Nose/Throat Y N _____
Bones/Joints Y N _____
Mental Illness Y N _____
Sexual Y N _____
Other Y N _____

3. Please list any hospital admissions including any surgical or psychiatric admissions:

Date	Reason	Location

4. What was the date of your last physical exam? _____

Physician: _____

Results: _____

5. Please list any medications, prescribed or over-the-counter, used either regularly or occasionally:

Medication	Amount	Frequency	Reason Used	Date Started	Prescribing Physician

6. List any known allergies: _____

7. Have you ever taken any medication (prescription or over-the-counter) to help you go to sleep or to help you stay awake? Y N

If yes, please specify: _____

8. For each of the beverages listed below, write the average amount you drink daily:

Coffee ___/day Decaffeinated Coffee ___/day Tea ___/day

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Soft Drinks ___/day Decaffeinated soft drinks ___/day Alcoholic beverages ___/day

9. Do you smoke tobacco? Y N

If so, how much do you smoke per day? Packs of cigarettes ___/day___years

Cigars ___/day___/years Pipe___/day___years

10. Have you ever used any "street" drugs?

Marijuana	Y	N
Cocaine	Y	N
Hallucinogenic drugs (LSD, mescaline, PCP)	Y	N
Stimulants (uppers, diet pills)	Y	N
Depressants (downers)	Y	N
Narcotics (heroin, morphine, opium)	Y	N
Other (glue sniffing, etc.)	Y	N

If you answered yes to any of these substances, please specify how much, how often and how long.

11. If employed, what are your usual working hours: Start___am/pm Stop___am/pm

12. Do you work split shifts (work day broken up into two or more separate work periods)? Y N

13. Does your job involve weekend work? Y N

14. At the present time, do you work at more than one job? Y N

15. How many hours per week do you work? ___hours

16. Does your work involve traveling across time zones? Y N

17. What time do you usually go to bed weekdays? ___am/pm Get up? ___am/pm

18. How do you normally awaken (circle)? Alarm clock Spontaneous Other_____

19. Do you snore? Y N

20. Does anyone complain about your snoring? Y N

21. Do you hold your breath or stop breathing during sleep? Y N

22. Do you ever awaken wheezing or short of breath? Y N

23. Do you have restless sleep? Y N

24. Do you awaken with headaches? Y N

25. Do you sweat excessively during the night? Y N

26. Are you bothered by frequent awakening during the night? Y N

If so, on average, how often do you wake up during the night? ___times/night

27. How many nights per week are you bothered by these awakenings? ___times/week

28. Do your legs twitch or kick during the night while you are asleep? Y N

29. Do you have leg cramps or crawling sensations in your legs while trying to go to sleep? Y N

How often? ___nights/week

30. Do you awaken with leg cramps? Y N

31. Do you have trouble getting to sleep at night? Y N

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32. How long does it usually take you to go to sleep? _____minutes
33. Is your sleep ever disturbed by indigestion, gas or heartburn? Y N
34. Do you grind your teeth during sleep? Y N
How often? _____nights/week
35. Do you walk in your sleep? Y N
How often? _____nights/week
36. Do you awaken from sleep screaming, violent and confused? Y N
How often? _____nights/week
37. Do you ever wet the bed? Y N
38. Is it difficult for you to awaken and get out of bed after sleeping? Y N
39. How long does it take you to feel alert and functioning after sleeping? _____minutes
40. Are you bothered by sleepiness during the day? Y N

If yes, complete using the following scale:

0 = would **never** doze

1 = **slight** change of dozing

2 = **moderate** chance of dozing

3 = **high** chance of dozing

Situation	Chance of Dozing (0-3)
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

41. Have you ever had a car accident because of falling asleep at the wheel? Y N
42. Any family history of narcolepsy? Y N
43. Do you feel refreshed after a short nap? Y N
44. Have you ever discovered that you have performed a complex act, such as driving a car to the wrong destination and not remembered how you did it? Y N
45. Do you ever have episodes of sudden muscle weakness (paralysis or inability to move) when laughing, angry or startled? Y N
46. Have you ever experienced weakness or paralysis upon:
- | | | | | | |
|--------------------|---|---|-------------------|---|---|
| On going to sleep? | Y | N | During the night? | Y | N |
| Upon awakening? | Y | N | During the day? | Y | N |
47. Do you feel you are depressed? Y N
48. When falling asleep at night, do you ever:
- | | | |
|---|---|---|
| Have thoughts racing through your mind? | Y | N |
| Feel sad or depressed? | Y | N |
| Feel muscle tension? | Y | N |

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- Feel afraid that you might not be able to go to sleep? Y N
49. Are you often awakened by noise or other environmental factors? Y N
50. How many pillows do you use at night? _____
51. Which positions do you sleep in? Please circle all that apply.
- Back Stomach Right side Left side

52. If there are any other aspects of your sleep/wake behavior or problems not covered by this questionnaire, please describe them here and list anything else not yet covered which especially interferes with your sleep or wakefulness that might be helpful to the interpreting physician or the technologist.
