



Patient Questionnaire

Name: _____

Date of Birth: _____ Today's Date: _____

What is your main sleep complaint and how long has it occurred?

Have you ever had a sleep study before? If yes, please tell us when and where it occurred.

Please check all the boxes that currently apply to you:

| | | |
|--|---|--|
| Neurological | Gastrointestinal | Ear/Nose/Throat |
| <input type="checkbox"/> Headaches <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Memory Loss <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Weakness | <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody or black stools <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear aches <input type="checkbox"/> Sinus pain <input type="checkbox"/> TMJ pain or clicking (jaw) <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Hoarseness |
| Heart | Musculoskeletal/Skin | Eyes |
| <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Muscle pain <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Rash | <input type="checkbox"/> Visual change <input type="checkbox"/> Eye pain |
| Lung | Allergy/Immunology | Endocrine |
| <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing | <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Eczema | <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Hot flashes |
| Kidney/Bladder | General | Blood |
| <input type="checkbox"/> Urinate frequently <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Sexual Difficulty | <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexpected weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Irritability | <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising/bleeding |
| | | Psychiatric |
| | | <input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Depression/sadness |

Current Weight: _____ lbs

Height: _____ ft _____ inches

Weight One Year Ago: _____ lbs

Weight Five Years Ago: _____ lbs

Medication ALLERGIES below (if more space needed, please write on the back):

| Medication | Allergic Reaction |
|------------|-------------------|
| 1) | |
| 2) | |
| 3) | |
| 4) | |

Have you ever had any of the following medical conditions? (Check all that apply)

| | | |
|--|--|--|
| Heart Disease <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Angina <input type="checkbox"/> Atria fibrillation <input type="checkbox"/> Arrhythmia <input type="checkbox"/> High blood pressure | Gastrointestinal <input type="checkbox"/> Liver disease <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Reflux disease <input type="checkbox"/> Colitis | Neurology <input type="checkbox"/> Stroke or TIA's <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Seizure <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Head injury |
| Lung Disease <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia | Ear/Nose/Throat <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Season allergies <input type="checkbox"/> Nasal surgery <input type="checkbox"/> Hard/soft palate surgery <input type="checkbox"/> Tonsillectomy Age: _____ | Endocrine <input type="checkbox"/> Diabetes: Type: ____ <input type="checkbox"/> Thyroid disease |
| Musculoskeletal <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Spine/Back surgery | Kidney/Bladder <input type="checkbox"/> Kidney failure <input type="checkbox"/> Enlarged prostate Psychiatric <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dementia <input type="checkbox"/> Chemical dependency | Miscellaneous <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clots <input type="checkbox"/> Major trauma: _____ <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Leukemia or lymphoma |

Please list any past surgeries or illnesses not mentioned above:

| Type of Surgery or Illness | Date |
|----------------------------|------|
| | |
| | |
| | |
| | |
| | |

Place an X in the appropriate boxes if your family members have had any of the following conditions:

| | Father | Mother | Siblings | Children |
|---------------------|--------|--------|----------|----------|
| Cancer | | | | |
| Diabetes | | | | |
| High Blood Pressure | | | | |
| Stroke | | | | |
| Heart Disease | | | | |
| Insomnia | | | | |
| Narcolepsy | | | | |
| Snoring | | | | |
| Sleep Apnea | | | | |
| Restless Legs | | | | |

Occupation: _____

What is your work schedule? _____

Marital status:

- Single Domestic Partner
 Married Widowed
 Separated Divorced

Children:

- None
 Yes, but not living with me
 Yes, living with me Ages: _____

Do you currently drink alcohol? Yes No

Do you have a drink just prior to going to bed? Yes No

Do you currently use tobacco products? Yes No/never No/stopped

If you had a history of tobacco usage but have quit using them, when did you quit? _____

Do you currently drink caffeinated beverages? Yes No

If please, how many per day: Cans of Soda: _____ Cups of Coffee: _____ Glasses/Cups of Tea: _____

At what time of day/night do you have your last caffeinated beverage? _____ a.m./p.m.

Please complete the schedule below:

| Days of the week | Time you go to bed | Time you get out of bed |
|---|--------------------|-------------------------|
| On weekdays/work days, what is your current schedule? | | |
| On weekend/days off, what is your current schedule? | | |
| What would be your ideal schedule? | | |

Do you eat, argue, worry, write, and/or read in bed? Yes No

If yes, specify: _____

Do you have difficulty falling asleep? Yes No

If yes, how long does it take? _____ # minutes/hours _____ # of nights weekly

Do you have several awakenings during the night? Yes No

If yes, _____ # of times nightly _____ # of nights weekly

Why do you awaken? _____

Do you have extended periods of wakefulness during the night? Yes No

If yes, _____ # minutes/hours _____ # of nights weekly

Do you awaken too early in the morning and stay awake? Yes No

If yes, at what time _____ a.m. _____ # of times weekly

Did you have any sleep problems as a child? Yes No

If yes, specify: _____

For the following situations, indicate the chance of dozing or falling asleep (not feeling tired) by using the scale below:

0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing

| <u>SITUATION</u> | <u>CHANCE OF DOZING</u> |
|---|-------------------------|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting inactive in a public place (e.g., a meeting or a theatre) | _____ |
| 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 lunch without alcohol | _____ |
| In a car while stopped for a few minutes in traffic | _____ |
| Total = | _____ |

Have you ever had an accident or near miss because of dozing while driving? Yes No

If yes, when and describe: _____

Some of the following questions will ask you to rate the frequency of certain symptoms. If you check yes to any of the boxes, please use the scale below as a guide when answering the questions.

Never=it does not occur

Occasionally = 1 or more times per month

Frequently = 1 or more times per week

Rarely= the issue occurs but it is less than the above

Place an X in the most appropriate box

| Question | Never | Rarely | Occasionally | Frequently |
|---|-------|--------|--------------|------------|
| Do you currently have intense nightmares or night terrors? | | | | |
| Do you ever have exceptionally vivid dreams while falling asleep? | | | | |
| Do you have <u>sudden</u> muscle weakness when you laugh or are angry? | | | | |
| Do you have <u>sudden</u> muscle weakness when you are angry? | | | | |
| Do you feel paralyzed as you are falling asleep or waking up? | | | | |
| Do you currently grind or clench your teeth at night? | | | | |
| Do you currently talk in your sleep? | | | | |
| Do you currently walk in your sleep? | | | | |
| Do you awaken to urinate? | | | | |
| Do you currently have incontinence of urine during sleep? | | | | |
| Does your bed partner complain about your excessive moving? | | | | |
| Do you awaken yourself by kicking your legs? | | | | |
| Has your bed partner ever complained of leg kicks? | | | | |
| Do you have a restless sense of discomfort in your legs while resting or before falling asleep? | | | | |
| Have you been told you stop breathing during sleep? | | | | |
| Do you snore? | | | | |
| Do you ever awaken gasping for air? | | | | |
| Do you awaken with a dry mouth? | | | | |
| Do you awaken with nasal congestion? | | | | |
| Do you awaken with morning headaches? | | | | |
| Do you awaken with a sore throat? | | | | |
| Do you have night sweats? | | | | |
| Do you have heartburn at night? | | | | |
| Do you feel unrefreshed after sleeping? | | | | |
| Are you ever confused in the morning? | | | | |
| Do you feel depressed? | | | | |
| Do you have problems with memory/concentration? | | | | |
| Do any of your children and/or pets sleep in the bedroom with you? | | | | |

Please list all list the medications you currently take (including over-the-counter):

| Medication | Dose (ie, mg strength) | Times Per Day | Prescribing Doctor (if prescription) |
|------------|------------------------|---------------|---|
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Please list the names/address/phone numbers of the doctors you would like to receive reports from our clinic:

| Name | Address | Phone Number |
|------|---------|--------------|
| | | |
| | | |
| | | |

I hear by give permission to Texas Sleep Medicine to release my medical records to the above providers. This information may be disclosed by fax, by mail, or by oral communication. I understand that my records are protected and cannot be disclosed without this written consent. I also understand that I may revoke this consent by written communication except to the extent that action has already been taken in reliance on it (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand. This authorization shall remain valid until revoked by me in writing.

Signature

Date