Baystate Regional Sleep Program

BAYSTATE MEDICAL CENTER

Neurodiagnostic and Sleep Center Phone: 413-794-5600 Fax 413-787-5713 Baystatehealth.com/sleep

New Patient Sleep Questionnaire

Patient Name: _____ **Date:** _____

Referring MD: _____ **PCP:** _____

Insurance: _____ **Date of Birth:** _____

Pharmacy: _____ **Best Phone number:** _____

Home Care Company: Regional Reliable Apria Flynn's J&L/Lincare
Sleep Medicine Services Sleep Management Solutions Other_____

Age: ___ Sex: Male / Female Height: _____ (inches) Weight: ____ (lbs.)

Email: _____ **Are you on Baystate Patient Portal?** Y N

What is the **primary reason** you are being referred? _____
_____

When did your sleep problem/symptoms **start**? _____

Please estimate how likely you would be to **nod off or fall asleep** in the following scenarios **recently**
0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A = Not Applicable

_____ Sitting & reading
_____ Watching television
_____ Sitting inactive in a public place (i.e. theater)
_____ Passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic
_____ Total Score

Sleep Schedule:

On **week or work** days, I typically go to bed at _____ and wake at _____ and sleep ____ hours.
On **weekends**, I typically go to bed at _____ and wake at _____ and sleep _____ hours.
It typically takes me _____minutes or hours **to fall asleep**.
I typically **wake** _____ times **at night** and it takes _____ minutes or hours **to fall back** to sleep.
I typically use the **bathroom** _____ times at night.
I typically **nap** for _____ amount of time _____ days per week.
I typically **sleep** for _____ hours in a 24 hour period.

I awaken at night due to: ☐ need to go to bathroom ☐ snoring/gasping ☐ worrying/anxiety
☐ mind racing ☐ pain ☐leg movements ☐generalized restlessness ☐leg cramps ☐ children
☐ night sweats ☐ pets ☐ dreaming ☐ stress in the day ☐ noises ☐ too hot or cold
☐ bed partner ☐ heartburn ☐ other _____

NOTE: 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A =not applicable

1. Has anyone ever told you that you **snore** at night? 0 1 2 3 N/A
   i. Check here if you don't know whether or not you snore ☐
2. Is your snoring **loud**? 0 1 2 3 N/A
3. Does your **snoring bother** other people? 0 1 2 3 N/A
4. Have you ever been told that you **stop breathing during sleep**? 0 1 2 3 N/A
5. Do you ever wake up from sleep **gasping for air**? 0 1 2 3 N/A
6. Do you get the **irresistible urge to sleep** despite wanting very much to stay awake? 0 1 2 3 N/A
7. Have you had any accidents or near-**accidents while driving** due to sleepiness? 0 1 2 3 I don't drive
8. Do you have **daytime fatigue** or **decreased energy**? 0 1 2 3 N/A
9. Are you still **tired/unrefreshed** when you awaken in the morning? 0 1 2 3 N/A
10. Do you have **headaches** upon awakening in the morning? 0 1 2 3 N/A
11. Do you have **nasal congestion**? 0 1 2 3 N/A
12. Do you **breathe through your mouth** when you sleep? 0 1 2 3 N/A
13. Do you **sleep on your back**? 0 1 2 3 N/A
14. Do you have **nightmares**? 0 1 2 3 N/A
15. Do you have **leg jerks** during sleep? 0 1 2 3 N/A
16. Do you have an **urge or sensation to move your legs that is worse** in the evening or night and at least temporarily improves with activity? 0 1 2 3 N/A
17. Do you **dream during short naps**? 0 1 2 3 N/A
18. Do you **grind your teeth** at night? 0 1 2 3 N/A
19. Do you have an **urge or sensation to move your legs that is worse** in the evening or night and at least temporarily improves with movement? 0 1 2 3 N/A
20. I ☐ have ☐ have *not* had **sudden weakness or limpness when emotional?** (ie. Knee buckling, jaw dropping, falling to the ground when laughing, crying, angry)
21. I ☐ have ☐ have *not* **felt paralyzed** (momentary inability to move) when waking up?
22. I ☐ have ☐ have *not* had **vivid lifelike images** or hallucinations on falling asleep?
23. I ☐ have ☐ have *not* **eaten in your sleep** without realizing it? (ie. find empty food cartons)
24. I ☐ have ☐ have *not* had **acted out your dreams** in your sleep? (ie. Yell, punch, kick or other movements in the setting of dreams)
25. I ☐ have ☐ have *not* had **sleepwalking**? ☐ As a child ☐ More recently

Patient Name: _____ **Date of Birth:** _____

Sleep Studies and CPAP Use (if applicable):

1. Have you ever had a sleep study? Where? When?_____
2. Are you currently using CPAP/BiPAP? ☐ Yes ☐ No What pressure? _____
3. How often do you currently use CPAP? _____ days/week _____ hours/night
4. If you are NOT using it now, did you use CPAP/BIPAP in the past? ☐ Yes ☐ No When? _____
5. If you are NOT using PAP now, how long did you use PAP? ___ days/months/years (circle) __ hours/ night
6. What type of mask(s) did you/ do you use? Full face Nasal Pillows Nasal Other
7. Did you or are you currently having trouble tolerating CPAP/BIPAP? ☐ Yes ☐ No Why?

☐ Skin irritation ☐Leakage ☐ Mask too tight ☐ Loose or uncomfortable headgear
☐ Dry mouth ☐ Condensation in tubing ☐ Machine too noisy ☐ Pressure seems excessive
☐ Pressure seems too weak/not enough air ☐ can't exhale easily ☐ Air too cold
☐ Other _____

Medical History: Do you have any of the following?

☐ Coronary artery disease
☐ Myocardial infarction (heart attack)
☐ Congestive heart failure, EF if known_____
☐ Atrial fibrillation
☐ Stroke/ TIA
☐ Hypothyroidism
☐ Diabetes Mellitus
☐ High blood pressure
☐ Obesity
☐ High cholesterol
☐ Asthma
☐ COPD (emphysema/chronic bronchitis)
☐ Pulmonary Hypertension
☐ Gastric reflux (heartburn)
☐ Seasonal allergies
☐ Depression
☐ Bipolar
☐ Seasonal affective disorder
☐ Anxiety
☐ Fibromyalgia
☐ Chronic fatigue syndrome
☐ ADHD
☐ Migraines
☐ Seizures/ Epilepsy
☐ Neuromuscular disorder
☐ Parkinson's disease
☐ Restless legs syndrome
☐ Broken nose
☐ Surgery on the nose
☐ Dental problems
☐ Sinus problems
☐ Deviated nasal septum
☐ Tonsillectomy
☐ Adenoids removed
☐ Kidney disease
☐ Anemia
Other: _____
_____

Social History:

Marital status: ☐ Single ☐Married/Partnered ☐Divorced/Separated ☐ Widowed
Do you share a bed with? (circle all that apply) Significant other Children Pets
Occupation: _____What is your work/ school schedule?_____
Tobacco: ☐ Yes _____# packs per day ☐ Never ☐ Quit When _____ # years _____
Alcohol: Assuming one glass of wine, one shot of liquor or one beer is one drink
I typically drink _____ on **weekdays** and _____ on **weekends**
Caffeine: How many caffeinated beverages (coffee, tea, soda) do you consume daily?
_____ 8 oz servings. What do you consume (ie. 8 oz coffee, 1 can soda)? _____
My last caffeinated beverage is at _____ ☐ AM ☐ PM
Drugs: Do you currently use recreational drugs (ie. Marijuana, cocaine)? ☐ Yes ☐ No
Exercise: I typically exercise _____ times per week around _____ time of day ☐ None

Family History: Does anyone in your **family** have a sleep disorder?

Snoring: ☐Father ☐Mother ☐Sibling ☐Child **Insomnia:** ☐Father ☐Mother ☐Sibling ☐ Child
Sleep apnea: ☐Father ☐ Mother ☐Sibling ☐Child **Narcolepsy:** ☐Father ☐Mother ☐Sibling ☐Child
Night Terrors: ☐Father ☐Mother ☐Sibling ☐Child **Sleep walking:** ☐Father ☐ Mother ☐Sibling ☐Child
Restless leg syndrome: ☐Father ☐ Mother ☐Sibling ☐Child

Drug Allergies: _____

List any medications you take on a daily basis including tranquilizers, stimulants, sleeping pills and herbal medications: *If you brought a list with you, we can copy it.* (Please continue on other side if needed)

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

In the past have you ever taken: ☐ Provigil/Modafanil ☐ Nuvigil/Armodafanil
☐ Ritalin/Methylphenidate ☐ Ritalin LA/SR ☐ Focalin ☐ Concerta
☐ Mixed amphetamine salts/ Adderall ☐ Adderall XR ☐ Vyvanse ☐ Xyrem

What sleep medications including herbal and over the counter have you tried in the past?
☐ Trazodone ☐ Ambien/zolpidem ☐Ambien CR ☐Lunesta ☐Sonata ☐Belsomra ☐Remeron
☐ Seroquel/quetiapine ☐Ativan/lorazepam ☐Valium ☐Clonazepam ☐Clonidine ☐Xyrem ☐Amitryptiline
☐ Melatonin ☐ Valerian root ☐ Tylenol or Advil PM ☐ Benadryl ☐ Other over the counter sleep med

Review of Systems: Please indicate if you have had these symptoms in the **last month**

General
☐ Night sweats
☐ Fevers
☐ Fatigue

Eyes, Ear, Nose, Throat
☐ Blurry vision
☐ Eye pain
☐ Loss of hearing
☐ Ringing in the ears
☐ Sore gums or tongue
☐ Jaw pain
☐ Hoarseness
☐ Mouth sores
☐ Nose bleeds

Cardiovascular
☐ Chest pain
☐ Palpitations
☐ Irregular heart beat
☐ Swollen feet or legs
☐ Lower leg pain when walking
☐ Shortness of breath lying flat

Hematologic
☐ Lymph node pain or swelling
☐ Easy bleeding
☐ Easy bruising
☐ Anemia
☐ Leg clots

Respiratory
☐ Shortness of breath
☐ Wheezing
☐ Chronic or frequent cough
☐ Spitting up blood

Gastrointestinal
☐ Loss of appetite
☐ Difficulty swallowing
☐ Heartburn
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Change in bowel movements
☐ Constipation
☐ Diarrhea
☐ Rectal bleeding

Muscle/ Skeletal
☐ Back pain
☐ Neck pain
☐ Joint pain
☐ Joint swelling
☐ Muscle cramps

Endocrine
☐ Excessive thirst
☐ Intolerance to heat
☐ Intolerance to cold
☐ Hot flashes

Genitourinary
☐ Unable to hold urine
☐ Excessive urination
☐ Blood in urine
☐ Irregular periods
☐ Kidney stones

Skin
☐ Rash
☐ Dry skin
☐ Hives or itching
☐ Change in hair or nails

Nervous / Mental
☐ Headaches
☐ Dizziness
☐ Loss of balance
☐ Fainting
☐ Light headed
☐ Memory loss
☐ Numbness
☐ Muscle weakness
☐ Tremors
☐ Depression
☐ Anxiety
☐ Stress
☐ Confusion

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